WE WOULD LIKE TO GET TO KNOW YOU BETTER!

PATIENT INFORMATION

PATIENT'S NAME: Last _____ First _____ MI ____ SEX : M F BIRTHDATE _____ AGE ____

SSN _____ If Patient is a minor, give Parent's or Guardian's Name _____ TODAY'S DATE _____

ADDRESS Street _____ City _____ State _____ Zip _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

E-MAIL _____ HOW DID YOU HEAR ABOUT US _____ REASON FOR THIS VISIT _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ MI _____ MARITAL STATUS _____

ADDRESS Street _____ City _____ State _____ Zip _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

SSN _____ BIRTHDATE _____ RELATION TO PATIENT _____ EMAIL _____

EMPLOYER _____ OCCUPATION _____ NO OF YEARS _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____

EMPLOYER _____ OCC _____

SSN _____ BIRTHDATE _____

HOME PH _____ CELL PH _____

WORK PH _____ EMAIL _____

EMERGENCY INFORMATION: RELATIVE

NAME _____

ADDRESS _____

HOME PHONE _____ CELL PHONE _____

WORK PH _____ RELATIONSHIP _____

DENTAL INSURANCE INFORMATION (PRIMARY)

Insured's Name _____

Insurance Co. _____

Insured's Employer _____

Insured's SSN _____ **Birthdate** _____

Insured's ID # _____ **Grp #** _____

If you have double dental insurance coverage, complete this for the second coverage

Insured's Name _____

Insurance Co _____

Insured's Employer _____

Insured's SSN _____ **Birthdate** _____

Insured's ID # _____ **Grp #** _____

ASSIGNMENT AND RELEASE I assign all insurance benefits, for services rendered, to Dr. Norberto Li. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Li may use and disclose my health care information to the insurance company(ies), and their agents for the purpose of obtaining payment and determining insurance benefits.

Signature of Patient, Parent, Guardian or Representative _____

Health History

Physician's Name_____ Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
			High Blood Pressure	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No			
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name_____

Phone (_____)_____

Allergies

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

Updates *(To be filled in at future appointments)*

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Date_____

Patient Name_____

Have you had any of the following Aerosol Transmissible Diseases?

Please check “yes” or “no”.

1. SARS yes__ no__
2. Meningitis yes__ no__
3. Pharyngitis yes__ no__
4. Pneumonia yes__ no__
5. Diphtheria yes__ no__
6. Rubella yes__ no__
7. Parvovirus B19 yes__ no__
8. Haemophilus Influenzae Type b (HIB) yes__ no__
9. Viral Hemmorrhagic (VHFs) yes__ no__
10. Pertussis or Whooping Cough yes__ no__
11. Group A Streptococcus (GAS) yes__ no__
12. Mycoplasmal Pneumonia yes__ no__
13. Avian Flu yes__ no__
14. Any Novel Flu yes__ no__
15. Anthrax yes__ no__
16. Shingles yes__ no__
17. Smallpox yes__ no__
18. Chicken pox yes__ no__
19. Seasonal flu yes__ no__
20. Measles yes__ no__
21. Novel H1N1 flu yes__ no__
22. Tuberculosis yes__ no__

Are you suffering from any of the following signs or symptoms of Aerosol Transmissible Diseases?

1. Have you had a cough for more than 3 weeks that is not explained by non-infectious conditions? yes__ no__

2. Have you had coughing fits that interfere with eating, drinking or breathing? Yes__ no__

3. In addition to cough, have you experienced: __unexplained weight loss (more than 5 lbs) __night sweats, __fever, __chronic fatigue or malaise, __coughing up blood.

4. Have you had fever, headache, stiff neck, chills, cough, runny nose, or watery eyes associated with the onset of an unexplained rash(diffuse rash or blister-type skin rash), or possibly mental status changes? __yes __no

5. Do you show signs and symptoms of a flu-like illness during March through October, (the months outside of the typical period for seasonal influenza in the USA), or do you show the signs and symptoms of flu for longer than 2 weeks at any time during the year? These signs and symptoms generally include combinations of the following: coughing and other respiratory symptoms, fever, sweating, chills, muscle aches, weakness and malaise. __yes __no

6. Have you been exposed to anyone with an infectious aerosol transmissible illness other than seasonal influenza? __yes __no

Name_____Signature_____