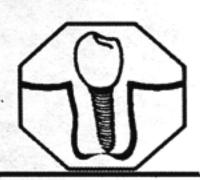


# Jeffrey C. H. Chow, DDS Diplomate, American Board of Periodontology



## Periodontics - Implants

#### www.jeffreychow-periodontics.com

**GREENFIELD MEDICAL - DENTAL CENTER** 2450 E. Guadalupe Rd., #104 • Gilbert, AZ 85234 Phone: 480-635-8787 • Fax: 480-635-8787

Mr. Mrs. Miss. Ms.	Date:			
NAME	EMAIL ADDRESS			
ADDRESS			ZIP	
MAILING ADDRESS (if different from a				
SOCIAL SECURITY#	HOME PHONE#	OTHER#	BIRTHDATE	
N CASE OF EMERGENCY, CONTACT	•			
NAME	RELATIONSHIP		PHONE#	
Responsible	Party Information	n		
JAME		DRIVER'S LICENSE#		
ADDRESS		CITY	ZIP	
SOCIAL SECURITY#	HOME PHONE#		BIRTHDATE	
EMPLOYED BY	OCCUI	PATION	HOW LONG	
MPLOYER ADDRESS			BUSINESS PHONE#	
POUSE OF RESPONSIBLE PARTY	OCC	UPATION	WORK PHONE#	
POUSE'S EMPLOYER	EMPLOYER ADI	DRESS		
Insurance In	iformation			
S PATIENT COVERED BY DENTAL INS				
NAME OF INSURED (person whose Insura	ince covers patient)	· .		
NSURED'S SS#	INSURED'S DATE	OF BIRTH		
NAME OF INSURANCE COMPANY	GROUP#			
S THERE A SECOND DENTAL INSURA	NCE THAT COVERS THIS PATIENT	?		
IAME OF INSURED (person whose insura	nce covers patient)			
NSURED'S SS#	INSURED'S DATE	OF BIRTH		
NAME OF INSURANCE COMPANY	i i		GROUP#	
	N IN APPROPRIATE SPACES AND	UNDERSTAND THA	HE INSURED PERSON COMPLETE EMPLOYEE T THE PORTION OF TREATMENT THAT IS NOT T.	
	IS DUE AND PAYABLE AT THE T	IME OF TREATMEN		
PAID BY THE INSURANCE COMPANY	find our about us			

WHOM MAY WE THANK FOR REFERRING YOU TO US FOR YOUR DENTAL CARE?\_\_\_\_\_

HAS ANY OTHER FAMILY MEMBER BEEN IN OUR OFFICE?\_\_\_\_\_YES\_\_\_\_\_NO RELATIONSHIP\_\_\_\_

#### Patient Medical History Date of Last Exam Office Phone Physician \_\_\_\_\_ Yes No Yes 9. Are you allergic to or have you had any reactions 1. Are you under medical treatment now? ..... to the following? 2. Have you ever been hospitalized for any Local Anesthetics (e.g. Novocaine) ..... surgical operation or serious illness within the last 5 years? Penicillin or any other Antibiotics ..... If yes, Please explain \_\_\_\_\_ Sulfa Drugs ..... Barbiturates ..... 3. Are you taking any medication (s) Sedatives ..... including non-prescription medicine? ..... Iodine ..... If yes, what medication (s) are you taking? Aspirin ..... Any Metals (e.g. nickel, mercury etc.) ..... Latex Rubber 4. Do you use tobacco?..... Other (please list) 5. Do you use controlled substances? ..... 10. Women Only: 6. Are you wearing contact lenses?..... a) Are you pregnant or think you may be pregnant? 7. Have you ever taken or are you currently taking one of these Bone b) Are you nursing?..... Sparing Medications to treat Osteoporosis and Osteopenia? If **Yes** - please complete the attached list. c) Are you taking oral contraceptives? ..... 8. Do you have or have you had any of the following? Chest Pains ..... Heart Disease ..... High Blood Pressure ..... Heart Attack ..... Easily Winded ..... Cardiac Pacemaker ..... Stroke ..... Heart Murmur..... Rheumatic Fever ..... Swollen Ankles ..... Hay Fever / Allergies ..... Angina ..... Tuberculosis ..... Fainting / Seizures ..... Frequently Tired ..... Asthma ..... Anemia ..... Radiation Therapy ..... Low Blood Pressure ..... Emphysema ..... Glaucoma ..... Cancer ..... Epilepsy / Convulsions ....... Recent Weight Loss ..... Liver Disease ..... Arthritis ..... Leukemia ..... Heart Trouble ..... Joint Replacement or Implant Diabetes ..... Resperatory Problems ..... Kidney Diseases ..... Hepatitis / Jaundice ..... Mitral Valve Prolapse ..... Sexually Transmitted Disease AIDS or HIV Posative ...... Thyroid Problem ..... Stomach Troubles / Ulcers ...... Other Patient Dental History Name of Previous Dentist and Loaction Date of Last Exam Yes Yes No 8. Do you have frequent headaches? ..... 1. Do your gums bleed while brushing or flossing? ...... 9. Do you clench or grind your teeth? ..... 10. Do you bite your lips or cheeks frequently? .... 3. Are your teeth sensitive to sweet or sour liquids/fooods? ..... 4. Do you feel pain to any of your teeth? ..... 11. Have you ever had any difficult extractons in the past?.... 5. Do you have any sores or lumps in or near your mouth? ..... 6. Have you had any head,, neck or jaw injuries? ..... 12. Have you ever had any prolonged bleeding following extractions?..... 7. Have you ever experienced any of the following 13. Have you had nay orthodontic treatment? ...... problems in your jaw? Clicking ..... 14. Do you wear dentures or partials? ...... Pain (joint, ear, side of face) ..... If yes, date of placement Difficulty in opening or closing ..... 15. Have you ever received oral hygiene instruction Difficulty in chewing ..... regarding the care of your teeth and gums?..... 16. Do you like your smile?.....

### Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

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