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

Patient Information

Mr. Mrs. Miss. Ms. Date: _____

NAME_____ EMAIL ADDRESS_____

ADDRESS_____CITY_____ZIP_____

MAILING ADDRESS (if different from above)_____

SOCIAL SECURITY#_____HOME PHONE#_____OTHER#_____BIRTHDATE_____

IN CASE OF EMERGENCY, CONTACT

NAME_____RELATIONSHIP_____PHONE#_____

Responsible Party Information

NAME_____DRIVER'S LICENSE#_____

ADDRESS_____ CITY_____ZIP_____

SOCIAL SECURITY#_____HOME PHONE#_____BIRTHDATE_____

EMPLOYED BY_____OCCUPATION_____HOW LONG_____

EMPLOYER ADDRESS_____BUSINESS PHONE#_____

SPOUSE OF RESPONSIBLE PARTY_____OCCUPATION_____WORK PHONE#_____

SPOUSE'S EMPLOYER_____EMPLOYER ADDRESS_____

Insurance Information

IS PATIENT COVERED BY DENTAL INSURANCE? _____ YES _____NO

NAME OF INSURED (person whose Insurance covers patient)_____

INSURED'S SS#_____INSURED'S DATE OF BIRTH_____

NAME OF INSURANCE COMPANY_____GROUP#_____

IS THERE A SECOND DENTAL INSURANCE THAT COVERS THIS PATIENT?_____

NAME OF INSURED (person whose insurance covers patient)_____

INSURED'S SS#_____INSURED'S DATE OF BIRTH_____

NAME OF INSURANCE COMPANY_____GROUP#_____

AS A COURTESY TO YOU WE WILL BILL YOUR INSURANCE, HOWEVER, WE ASK THAT THE INSURED PERSON COMPLETE EMPLOYEE INFORMATION ON EACH FORM, SIGN IN APPROPRIATE SPACES AND UNDERSTAND THAT THE PORTION OF TREATMENT THAT IS NOT PAID BY THE INSURANCE COMPANY IS DUE AND PAYABLE AT THE TIME OF TREATMENT.

How did you find our about us?

OUR PRACTICE GROWS BY REFERRALS FROM OUR DENTAL FAMILY.

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

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, Please explain _____	☐	☐
3. Are you taking any medication (s) including non-prescription medicine? If yes, what medication (s) are you taking? _____	☐	☐
4. Do you use tobacco ?	☐	☐
5. Do you use controlled substances ?	☐	☐
6. Are you wearing contact lenses ?	☐	☐
7. Have you ever taken or are you currently taking one of these Bone Sparing Medications to treat Osteoporosis and Osteopenia? If **Yes -** please complete the attached list.		

9. Are you allergic to or have you had any reactions to the following ?

	Yes	No
Local Anesthetics (e.g. Novocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list)	☐	☐

10. Women Only:

	Yes	No
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing ?	☐	☐
c) Are you taking oral contraceptives ?	☐	☐

8. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Resperatory Problems	☐	☐
AIDS or HIV Posative	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other _____	☐	☐

Patient Dental History

Name of Previous Dentist and Loaction _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing ?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods ?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/fooods ?	☐	☐
4. Do you feel pain to any of your teeth ?	☐	☐
5. Do you have any sores or lumps in or near your mouth ?	☐	☐
6. Have you had any head,, neck or jaw injuries ?	☐	☐
7. Have you ever experienced any of the following problems in your jaw ?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches ?	☐	☐
9. Do you clench or grind your teeth ?	☐	☐
10. Do you bite your lips or cheeks frequently ?	☐	☐
11. Have you ever had any difficult extractons in the past ?	☐	☐
12. Have you ever had any prolonged bleeding following extractions ?	☐	☐
13. Have you had nay orthodontic treatment ?	☐	☐
14. Do you wear dentures or partials ?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instruction 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.

X _____

Signature of patient (or parent if minor)