

PATIENT REGISTRATION

Date		You Were Referred To Us By			
Last Name		First		M.I.	
Address		Home Phone No.		Work	
City		State, Zip		Cell Phone No.	
Email					
Birthday	Age	Male / Female	Single	Married	Other
Social Security Number		Driver's License Number		Occupation	
Person To Contact For Emergency			Relationship To Patient		Contact Phone No.
<p>Authorization To Provide Dental Treatment To Minor (if applicable)</p> <p>My signature below indicates that I authorize Dr. Ka-Wing Chew and/or his associates to render any and all dental treatment for the above named patient. I understand I am financially responsible for any and all treatment rendered. This authorization remains in effect until the 18th birthday of the patient or revoked by the above named guardian in writing.</p> <p>Signature of Parent/Guardian _____ Date _____</p>					

MEDICAL HISTORY

- Have you been hospitalized or had surgical operation or serious illness within the past five years? Yes No
- Are you taking any medication, drugs or controlled substances, including regular dosage of aspirin? Yes No
If yes, please list name and dosage: _____
- Do you smoke or chew tobacco? Yes No
- Have you lost or gained more than 10 pounds in the past year? Yes No
- <Women> Are you: Pregnant? Yes, ____ Months/ No Nursing? Yes/ No Taking birth control pills? Yes/ No
- Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes No
If yes, please list: _____
- Circle and Indicate which of the following you have had, or have at present.

Heart (Surgery, Disease, Attack)	Ulcers	Cold Sores / Fever Blisters
Heart Pacemaker	Diabetes	Blood Transfusion
Chest Pain	Thyroid Problems	Hemophilia
Congenital Heart Disease	Anemia	Liver Disease
Heart Murmur	Chronic Cough	Yellow Jaundice
High / Low Blood Pressure	Tuberculosis	Mitral Valve Prolapse
Rheumatic Fever	Hay Fever	Sickle Cell Disease
Arthritis / Rheumatism	Latex Sensitivity	Bruise Easily
Swollen Ankles	Allergies or Hives	Neurological Disorders
Epilepsy or Seizures	Sinus Trouble	Psychiatric / Psychological Care
Fainting or Dizzy Spells	Radiation Therapy	Sexually Transmitted Disease
Asthma	Chemotherapy	Glaucoma
Leukemia	Tumors	Emphysema
Stroke	Hepatitis A B C (circle)	Angina
Diet (Special/Restricted)	Venereal Disease	Cortisone Medicine
Artificial Joints (hip, knee, etc)	A.I.D.S	Artificial Heart Valve
Kidney Diseases	H.I.V. Positive	Lung Problems
- Do you have or have you had any disease, condition, or problem not listed? Yes No
If yes, please list: _____
- Do your gums bleed while brushing or flossing? Yes No
- Are your teeth sensitive to hot, cold, sweet or sour liquids or foods? Yes No
If yes, please indicate what and where: _____
- Do you have a toothache? If yes, please indicate where: _____ Yes No
- Have you ever had injuries to your head, neck or jaw? Yes No
- Do you have any jaw joint problems? (i.e. clicking, painful joints, difficulty in chewing, headaches) Yes No
- Do you have a bleeding problem? (i.e. prolong bleeding following tooth extraction) Yes No
- Have you had braces or orthodontic treatment? Yes No
- Do you wear dentures, plates, or partials? If yes, date of placement: _____ Yes No

Patient/ Guardian Signature _____ Date _____

OFFICE AND FINANCIAL POLICIES

- 1. General Consent To Treatment** I hereby authorize my doctor and designated staff to perform any and all forms of procedures deemed appropriate by the doctor, which include but not limited to examination, radiographic survey, dental cleaning, restoration and filling of teeth, gum treatment, extraction, etc., to enable a thorough diagnosis and treatment for (name of patient) _____.
- 2. Adult / Minor Patients** Adult patients are responsible for full payment at time of service. The parent/guardian who brings the minor patient in for treatment is responsible for payment. Our office will not provide service for unaccompanied minors unless consent to treat and advance financial arrangements have been made.
- 3. Dental Insurance** I understand that I am solely responsible for my entire account balance regardless of my insurance. Any insurance benefits or coverage information provided, as a courtesy to me by this office, is not a guarantee of eligibility or payment. I shall be responsible for any remaining balance, fees, deductibles, estimated portions and co-payments for my account.
- 4. Assignment of Dental Benefits** I assign dental benefit payment from my insurance company to be paid directly to the doctor. I authorize the release of this form, and any medical and dental information necessary for the process of my insurance submissions.
- 5. Late Charge** A late fee of \$25.00 will be added to the remaining balance if payment is not received by the due date.
Returned Check A service fee of \$25.00 will be applied to each returned check.
Default Ten days after the due date without payment, the account will be considered in default. In such a case, the entire balance shall become past due, including all collection fees and charges.
- 6. Appointment Policy** It is your responsibility to remember your appointment. Please notify us 24 hours in advance if you are unable to keep your appointment. Failure to do so will result in a broken appointment charge of \$25.00 on your account.

I have read, understand, and agree to comply with the foregoing Office and Financial Policies. I will ask for further explanation if I have any questions regarding these policies. I understand that I am entitled to have a copy of this form.

Signature of Patient/Guardian _____ Date _____

Receipt of Notice of Privacy Practices & Dental Material Fact Sheet

My signature below indicates that I have received a copy of:

1) This office's **Notice of Privacy Practice**

2) The **Dental Materials Fact Sheet** developed by the Dental Board of California.

We are required by law that each patient be given a copy. It discussed and compared many types of dental Materials to restore cavities and to replace missing teeth.

Signature of Patient/Guardian _____ Date _____

For Office Use Only

We were unable to obtain written acknowledgement of receipt of foregoing documents because:

____ Individual refused to sign

____ Communication barriers prohibited us from obtaining such acknowledgement

____ An emergency situation occurred

____ Others Reasons _____

KA-WING CHEW, D.D.S.

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