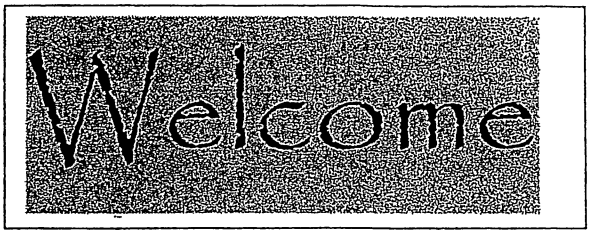

JACK FAN, D.D.S., PLLC

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental needs, please fill out this form completely.
If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information

Full Name_____ Preferred Name_____ Date of Birth_____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered

Home Phone_____ Mobile Phone_____ Best time to call?_____

Address_____ Apt. #_____ City_____ State_____ Zip Code_____

E-Mail Address_____ SS# _____

If Student, Name of School/College_____ City/State_____ Full Time/Part Time_____

Employer_____ City/State_____ Phone_____

How did you hear of our office?_____

Emergency Contact_____ Phone_____

Responsible Party

Name of Person Responsible for this account_____ Relationship to Patient_____

Date of Birth_____ Social Security Number_____

Home Phone_____ Daytime Phone_____

Address_____ City_____ State_____ Zip code_____

Insurance Information

Insurance Company_____ Phone_____

Name of Subscriber_____ Relationship to Patient_____

Subscriber ID_____ DOB_____

Employer_____ City/State_____ Group #_____

Subscriber's Address (if different than above)_____

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 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 payors 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_____ Date _____

Signature of patient (or parent/guardian if patient is a minor)

OVER...

Health History

Date of last dental visit_____ Date of last Full-Mouth Series of X-rays_____

Previous Dentist Name_____ Location_____ Phone_____

Reason for today's visit?_____

Have you ever had any of the following? Please check Yes or No.

YES	NO		YES	NO		YES	NO	
☐	☐	AIDS	☐	☐	Excessive Bleeding	☐	☐	Respiratory Problems
☐	☐	Allergies	☐	☐	Fainting	☐	☐	Rheumatic Fever
		_____	☐	☐	Glaucoma	☐	☐	Sinus Problems
☐	☐	Alzheimer's	☐	☐	Head Injuries	☐	☐	Stomach Problems
☐	☐	Anemia	☐	☐	Heart Disease	☐	☐	Stroke
☐	☐	Arthritis	☐	☐	Heart Murmur	☐	☐	Thyroid Problems
☐	☐	Artificial Joints	☐	☐	Heart Valve Replacement	☐	☐	Tuberculosis
		If Yes, Date:_____			If Yes, Date:_____	☐	☐	Tumors
☐	☐	Asthma	☐	☐	Hepatitis	☐	☐	Ulcers
☐	☐	Blood Disease	☐	☐	High Blood Pressure	☐	☐	Venereal Disease
☐	☐	Cancer	☐	☐	Kidney Disease	☐	☐	Codeine Allergy
☐	☐	Diabetes	☐	☐	Liver Disease	☐	☐	Penicillin Allergy
☐	☐	Dizziness	☐	☐	Mitral Valve Prolapse	☐	☐	Other:
☐	☐	Epilepsy	☐	☐	Radiation Treatment			_____
								_____

Please list all medications that you are currently taking: _____

Females, are you currently pregnant? ☐Yes ☐No If Yes, Due Date: _____

Have you ever had complications following dental treatment? ☐Yes ☐No

If yes, please explain:_____

Have you been admitted to a hospital or needed emergency care during the last two years? ☐Yes ☐No

If yes, please explain:_____

Are you now under the care of a physician? ☐Yes ☐No

If yes, please explain:_____

Name of Physician:_____ Phone:_____

Do you have any health problems that need further clarification? ☐Yes ☐No

If yes, please explain:_____

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.

X_____ Date _____

Signature of patient (parent/guardian if patient is a minor)

Changes to Health History?_____ _____ _____ _____ _____ _____