Date _____

Name (Last, First, Middle) _____ Nickname _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Cell Phone _____ Email Address _____

Social Security Number _____ Birth Date _____

Sex _____ Marital Status _____ Spouse Name _____

Employer _____ Present Position _____ How Long _____

Address _____ City _____ State _____

If Patient is a college student, enter name and address of school

_____

Please enter name, phone number and relationship of person(s) to be contacted in case of emergency

_____

If a minor, please provide parent information, or if married, please provide spouse information

Employed By _____ Phone Number _____

Address, City and State _____

Present Position _____ How Long _____

Social Security Number _____ Birth Date _____

DO YOU HAVE DENTAL INSURANCE (Please check one) ☐YES (go to #1) ☐NO (go to #5)

#1 Prime Carrier

Dental Insurance Co Name _____ Group Number _____

Name of Insured _____ Effective Date _____

Union Local _____

#2 Secondary Carrier

Dental Insurance Co Name _____ Group Number _____

Name of Insured _____ Effective Date _____

Union Local _____

#3 I authorize release of any information to my insurance company relating to claims for which I have been or will be treated.

Signature of Patient/Parent/Gardian_____

#4 I hereby authorize payment directly to the office of Dr. Michael Wu, D.D.S. of the group insurance benefits otherwise payable to me.

Signature of Patient/Parent/Gardian_____

#5 IF NO INSURANCE COVERAGE, PLEASE ENTER NAME, ADDRESS, RELATIONSHIP, AND SOCIAL SECURITY NUMBER OF PERSON(S) RESPONSIBLE FOR THIS ACCOUNT

_____

_____

Who referred you to us? _____

PLEASE PRINT. ALL INFORMATION IS CONFIDENTIAL 08/04/2005

PLEASE FILL OUT THE BACK OF THIS FORM
THANK YOU

Do you have a personal physician ☐YES ☐NO

Physician's Name _____ Physician's Phone Number _____

The approximate date of your last doctor's visit _____

Your current physical health is ☐GOOD ☐FAIR ☐POOR

Are you currently under the care of any physician ☐YES ☐NO

If yes, please explain _____

Do you smoke or use tobacco in any other form ☐YES ☐NO

Are you presently taking any drugs prescribed by a physician or dentist ☐YES ☐NO

If yes, please explain _____

For women, are you pregnant? ☐YES, Week # ☐NO

Have you taken the drug Phen-Phen? ☐YES ☐NO

Do you need to be premedicated before dental treatment? ☐YES ☐NO

Have you been hospitalized within the last 5 years? ☐YES ☐NO

If yes, please explain _____

Have you had any serious medical problems in the last 5 years? ☐YES ☐NO

If yes, please explain _____

Have you ever had any of the following diseases or medical problems?

☐YES ☐NO	Heart Attack/Stroke	☐YES ☐NO	Psychiatric Problems
☐YES ☐NO	Cancer/Chemotherapy	☐YES ☐NO	Epilepsy
☐YES ☐NO	Seizures	☐YES ☐NO	Fainting
☐YES ☐NO	Heart Murmur	☐YES ☐NO	Diabetes
☐YES ☐NO	Rheumatic Fever	☐YES ☐NO	Drug/Alcohol Abuse
☐YES ☐NO	HIV+/AIDS	☐YES ☐NO	Venereal Disease
☐YES ☐NO	Heart Surgery/Pacemaker	☐YES ☐NO	Hemophilia/Abnormal Bleeding
☐YES ☐NO	Shingles	☐YES ☐NO	Ulcers/Colitis
☐YES ☐NO	Mitral Valve Prolapse	☐YES ☐NO	Congenital Heart Defect
☐YES ☐NO	Kidney Problems	☐YES ☐NO	Anemia/Radiation Treatment
☐YES ☐NO	Artificial Bones/Joints	☐YES ☐NO	Asthma
☐YES ☐NO	Arthritis	☐YES ☐NO	Glaucoma
☐YES ☐NO	Sinus Problems	☐YES ☐NO	Emphysema
☐YES ☐NO	High Blood Pressure	☐YES ☐NO	Low Blood Pressure
☐YES ☐NO	Hepatitis	☐YES ☐NO	Tuberculosis (TB)
☐YES ☐NO	Fever Blisters	☐YES ☐NO	Blood Transfusion
☐YES ☐NO	Severe/Frequent Headaches		

Have you experienced any other problems that are not listed above? ☐YES ☐NO

If yes, please list

Are you allergic to any of the following drugs?

☐YES ☐NO	Penicillin	☐YES ☐NO	Aspirin
☐YES ☐NO	Erythromycin	☐YES ☐NO	Tetracycline
☐YES ☐NO	Dental Anesthetics	☐YES ☐NO	Codeine
☐YES ☐NO	Latex	☐YES ☐NO	Sulfa

Are you allergic to any other drugs? ☐YES ☐NO If yes, please list

ACKNOWLEDGEMENT AND AUTHORITY

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever drugs, medicine, performance or operations and conduct of laboratory, x-rays, or studies that may be used by the attending doctor, or his nurse or qualified assistant. I also acknowledge full responsibility for the payment of such services and agree to pay for them in full, at the time of service, unless other arrangements are made with the financial assistance.

Signed_____ Date_____

Patient or Parent/Guardian of Minor

Doctor's Signature_____ Date_____

Doctor's Website **mikewudds.com** **dreberle.com**