PATIENT REGISTRATION AND MEDICAL HISTORY

Date_____ (PLEASE PRINT) Home Phone_____

Cell Phone_____

Patient_____
Last Name First Name Initial Preferred Name

Address _____ Apt._____ City_____ State_____ Zip_____

Sex: ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed by_____ Occupation_____

Business Address_____ Business Phone_____

Spouse/Parent Name_____ Spouse/Parent Birthdate_____

Spouse/Parent Employed by_____ Occupation_____

Business Address_____ Business Phone_____

Who is responsible for this account?_____ Relationship to Patient_____

Social Security #_____ Spouse/Parent Social Security #_____

Name of Dental Insurance Company_____ Group Number_____

In case of emergency, who should be notified?_____ Phone_____

Whom may we thank for referring you?_____

MEDICAL HISTORY

Physician's Name_____ Date of Last Physical_____

Have you ever had any of the following? (check boxes that apply):

Yes	No		Yes	No		Yes	No	
☐	☐	Heart Problems	☐	☐	Epilepsy	☐	☐	Special Diet
☐	☐	High Blood Pressure	☐	☐	Headaches	☐	☐	Swollen Neck Glands
☐	☐	Low Blood Pressure	☐	☐	Hepatitis, Jaundice or Liver Disease	☐	☐	Rheumatic Fever
☐	☐	Circulatory Problems	☐	☐	Cancer	☐	☐	Sinus Problems
☐	☐	Nervous Problems	☐	☐	Psychiatric Care	☐	☐	"A.I.D.S." or Other Immunosuppressive Disorders
☐	☐	Radiation Treatment	☐	☐	Chronic Diarrhea			
☐	☐	Artificial Heart Valves or Joints	☐	☐	Allergies to Anesthetics	☐	☐	Stroke
☐	☐	Recent Weight Loss / used Fen-Phen	☐	☐	Allergies to Medicine or Drugs	☐	☐	Ulcer
☐	☐	Back Problems	☐	☐	General Allergies or Latex	☐	☐	Venereal Disease
☐	☐	Diabetes	☐	☐	Blood Disease	☐	☐	Chemical Dependency
☐	☐	Respiratory Disease	☐	☐	Arthritis	☐	☐	Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication?_____ If so, what_____

_____

Have you ever responded adversely to medical or dental treatment?_____

Are you taking any medication at this time?_____ If so, what_____

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

For what conditions?_____

If patient is a child, what is his/her weight?_____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history?_____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ Signature_____

(OVER)

DENTAL INFORMATION

(Please check which apply)

Yes	*No*	
___	___	Do your gums bleed when you brush?
___	___	Do you ever have bad breath or a bad taste in your mouth?
___	___	Are your teeth sensitive to heat or cold?
___	___	Are your teeth sensitive to pressure?
___	___	Are your teeth sensitive to sweets?
___	___	Do you grind or clench your teeth?
___	___	Do you have any fear of dental work?

Date of last dental examination_____What was done at that time?_____

What is the purpose of today's dental appointment?_____

How do you feel about the appearance of your teeth?_____

If you could change anything about your smile, what would you change?_____

If there were a simple and inexpensive way to whiten your teeth would you be interested?_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with_____
Name of Insurance Company(ies)

and assign directly to Dr. **MELISSA CHENG, D.D.S.** all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Date *Signature*

MINOR/CHILD CONSENT

I, being the parent or guardian of_____ do hereby request
Name of minor/child

and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____
Date *Signature of Insured/Guardian*

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

_____ _____
Date *Signature of Insured/Guardian*

General Dentistry Informed Consent

1. Work to be done: I understand that I am having the following work done: Filling ____, Bridges ____, Crowns____, Extractions ____, Impacted Teeth Removed ____, Sedation ____, Root Canals ____, Periodontal ____, Other_____ X-rays, Cleaning.

Initials: _____

2. Drugs, Medications and Sedation: I have been informed and understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction) and they can cause pain, thrombophlebitis (inflamation of the vein) from intravenous and intramuscular injections, injury to and stiffness of neck and facial muscles. They may cause drowsiness and lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given me in the office for my care. I understand that failure to take medications prescibed for me in the manner prescibed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition.

Initials: _____

3. Changes in Treatment Plan: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

Initials: _____

4. Removal of Teeth: Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ _____ and any others necessary for reasons in paragraph #3. I understand risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (parasthesia) that can last for indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

Date: _____ Tooth #: ____ Initials: _____ Date: _____ Tooth #: ____ Initials:_____
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Date: _____ Tooth #: ____ Initials: _____ Date: _____ Tooth #: ____ Initials:_____

5. Crowns, Bridges, Caps, Veneers and Bonding: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. It has been explained to me, in a very few cases, cosmetic procedures may result in need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

Date: _____ Tooth #: ____ Initials: _____ Date: _____ Tooth #: ____ Initials:_____
Date: _____ Tooth #: ____ Initials: _____ Date: _____ Tooth #: ____ Initials:_____
Date: _____ Tooth #: ____ Initials: _____ Date: _____ Tooth #: ____ Initials:_____

6. Dentures - Complete or Partial: I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

Initials: _____

7. Endodontics Treatment (Root Canal): I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from treatment, and that occasionally metal objects are cemented in the tooth or extended through the root which do not necessarily effect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment, the cost of which is my responsibility.

Date: _____ **Tooth #:** ____ **Initials:** _____ **Date:** _____ **Tooth #:** ____ **Initials:** _____
Date: _____ **Tooth #:** ____ **Initials:** _____ **Date:** _____ **Tooth #:** ____ **Initials:** _____
Date: _____ **Tooth #:** ____ **Initials:** _____ **Date:** _____ **Tooth #:** ____ **Initials:** _____

8. Periodontal Loss (Tissue and Bone): I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacement and/or extractions. I understand that undertaking any dental procedures may have future adverse effect on my periodontal condition.

Initials: _____

9. Temporomandibular Joint Dysfunction (TMD): I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility.

Initials: _____

10. Consequences of Not Performing Treatment: _____

_____

_____

_____

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I further acknowledge that I have been informed of the potential consequences of not performing treatment.

Signature: _____ Date: _____

Doctor: _____ Witness: _____

Patient Acknowledgment of receipt of Dental Materials Fact Sheet

I, _____, acknowledge that I have received from MELISSA CHENG D.D.S.
patient name — dentist or dental office name

a copy of the Dental Materials Fact Sheet dated October 2001.

_____
Patient Signature — Date

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