ELIZABETH C. CHENG, DDS, FAGD

GENERAL & FAMILY DENTISTRY

Date ________________

Home Phone ______________________ Work Phone______________________ Cell Phone ______________________

Patient ____

First Name | Middle Initial | Last Name | Preferred Name

Birthdate_________________ Age_____ Gender______ SSN_______________ ☐Single ☐Married ☐Widowed ☐Divorced

Mailing Address ____________________________________ City ___________________ State _____ Zip __________

Employer____ Occupation _____________________________

E-mail ____ Spouse Name ___________________________

In case of emergency, who should be notified? ___________________ Contact #______________________________

Who is responsible for this account? ___________________________ Relationship to Patient___________________

Whom may we thank for referring you? ____

FOR A MINOR:

Mother's Name ____ Contact #______________________________

Father's Name ____ Contact #______________________________

DENTAL INSURANCE

Name of Dental Insurance ____________________________________ Group Number__________________________

Subscriber's Name_________________________ Subscriber's Birthdate_____________ Subscriber's SSN_____________

Subscriber's Employer______________________ (If the insurance policy is not through an employer, write SELF)

MEDICAL HISTORY

Medical Doctor's Name _______________________________________ Preferred Pharmacy ______________________

Have you ever had a problem with medical or dental treatment? ____

In the past 5 years, have you had any serious illness, surgery or hospitalization? ___________________________

If so, explain. ____

List any prescription medications: (If none, please write NONE)

____ What is it for?______________________________________

____ What is it for?______________________________________

____ What is it for?______________________________________

____ What is it for?______________________________________

____ What is it for?______________________________________

____ What is it for?______________________________________

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

Have you ever had or take any of the following?

□Y □N Heart Problems	□Y □N Diabetes	□Y □N Anemia	□Y □N HIV-Positive/AIDS
□Y □N High Blood Pressure	□Y □N Stomach Ulcers	□Y □N Asthma	□Y □N Immune System Disorder
□Y □N Low Blood Pressure	□Y □N Kidney Disorder	□Y □N Head/Neck Radiation	□Y □N Bisphosphonates
□Y □N Artificial Heart Valve	□Y □N Pacemaker	□Y □N Heart Valve Replaced	(e.g. Fosamax, Boniva)
□Y □N Blood Thinners (Aspirin, Warfarin/Coumadin)	□Y □N Hepatitis, Jaundice, or Liver problems	□Y □N Cancer *Type & Date*:_____________	□Y □N Fainting Spells, Seizures or Epilepsy
□Y □N Heart Attack(s) *Date*: __________________	□Y □N Stroke(s) *Date*: ________________	□Y □N Premedication required by a physician If so, what?_______________	□Y □N Joint Replacement *Circle*: Hip Knee Shoulder *Year*: ______________________

Do you have any **drug allergies**? (Circle) YES NO If so, what? ____

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

____

How often do you drink these beverages? ◻ Coffee ◻ Soda ◻ Sweet Tea ◻ Water with Lemon ◻ Fruit Juice
◻ Rarely ◻ 1 – 2/day ◻ 3 – 4/day ◻ 5+/day
How often do you drink these alcoholic beverages? ◻ Beer ◻ Wine ◻ Hard Liquor
◻ Never ◻ Occasionally ◻ 1 – 2/day ◻ 3 – 6/day ◻ 6-12+ /day

Do you use tobacco of any kind? ◻Y ◻N If so, what kind? ◻ Cigarette ◻ Dip ◻ Pipe/Cigar ◻ Vape
How many times a day do you use tobacco? ______________________________
How many years have/did you use tobacco? ______________________________

DENTAL HISTORY

When was your last dental checkup? __________________
How often do you brush? ____________________________
How often do you floss? ____________________________

	Yes	No
Would you like a comprehensive exam of your teeth and gums?	◻	◻
Do you get nervous about dental treatment?	◻	◻
Have you had problems with previous dental treatment?	◻	◻
Do your gums bleed easily when you brush or floss?	◻	◻
Does food catch between your teeth regularly?	◻	◻
Do you have difficulty chewing your food?	◻	◻
Do you have periodontal (gum) disease?	◻	◻
Are your gums receding?	◻	◻
Do you brush your teeth hard?	◻	◻
Do you use a hard/ medium bristle toothbrush?	◻	◻
Do you use whitening toothpaste?	◻	◻
Are your teeth sensitive?	◻	◻

	Yes	No
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	◻	◻
Cold foods or liquids?	◻	◻
Sour/acidic foods or liquids?	◻	◻
Sweets?	◻	◻
Do you have any jaw pain or headaches upon waking in the morning?	◻	◻
Do you have temporomandibular jaw disorder (TMJ or TMD)?	◻	◻
Have you noticed any slow-healing sores or ulcers in your mouth?	◻	◻
Have you ever had trauma to the mouth/jaw?	◻	◻
Do you clench or grind your teeth?	◻	◻
Do your jaws ever pop or click?	◻	◻
Do you wear a night guard?	◻	◻
Are you aware of an uncomfortable bite?	◻	◻
Is there anything you would like to change about the appearance of your teeth or smile?	◻	◻

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

Date ________________________ Signature ____

Acknowledgement of Receipt of Notice of Privacy Practices

I, __________________________________ have viewed a copy of **Dr. Elizabeth Cheng's NOTICE OF PRIVACY PRACTICES**.

Signature ____

For Office Use Only:

Date __________ Initials_______ Date __________ Initials_______ Date __________ Initials_______

Date __________ Initials_______ Date __________ Initials_______ Date __________ Initials_______