Medical Information

Name: _____ Birthdate: _____ ☐ Male ☐ Female
Last First Middle Initial

Address: _____
(mailing) Street City State Zip Code

Address: _____ ☐ Single ☐ Married
(residence) Street City State Zip Code

Telephone (home): _____ Social Security # _____

Telephone (work): _____ext:_____ Employer: _____

If Child, Parent's or Legal Guardian's Name: _____

Name of Spouse: _____ Social Security # _____

Birthdate: _____ Employer: _____

Person Responsible for This Account: _____

In Case of Emergency Who Should We Notify? _____ Telephone: _____

Do You Have Dental Insurance? ☐ Yes ☐ No

Name of Insurance Company: _____ Effective Date: _____

Subscriber Name: _____ Social Security # _____ Birthdate: _____

Group or Policy #: _____ Membership #: _____Dental Plan #: _____

Is There Secondary Dental Insurance ☐ Yes ☐ No

Name of Insurance Company: _____ Effective Date: _____

Subscriber Name: _____ Social Security # _____ Birthdate: _____

Group or Policy #: _____ Membership #: _____Dental Plan #: _____

Health History: Name of Your Physician: _____ Date of Last Physical: _____

Are You Taking Any Medications? ☐ Yes ☐ No If Yes, What? _____

Do You Have Any Allergies (or Adverse Reactions) To Any Medications? ☐ Yes ☐ No

If Yes, What? _____

Please Circle Any of The Following That Apply:

Heart Problem	AIDS	Tuberculosis	Artificial Joints	Psychological or Psychiatric Treatment
Rheumatic Fever	HIV Antibodies	Emphysema	Abnormal Bleeding	
Hi Blood Pressure	Cancer	Asthma	Ulcers	Other: _____
Lo Blood Pressure	Hepatitis	Diabetes	Fainting	
Pacemaker	Tobacco Use	Epilepsy	Pregnant	**None Apply**

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ☐ Yes ☐ No

How were you referred to our office? _____

I grant authority to Ricci Chan, D.M.D. and his practice auxiliaries to perform dental and surgical procedures and treatments, including the administration of medicines and local anesthetics, that are deemed necessary and advisable.. Patient and/or legal guardian/parent will be informed before treatment is performed.

I authorize the practice of Ricci Chan, D.M.D. to release any information necessary to expedite insurance claims. I understand that I am ultimately responsible for ANY and ALL charges regardless of insurance coverage.

I consent to the taking of photographs and videos before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

I hereby certify the above to be true and correct to the best of my knowledge.

Authorized Signature: _____ Date: _____

Your signature is a file signature for insurance and credit card purchases

EMAIL: _____