Emily Y. Chen, DDS, MA

ADVANCED DENTAL RESTORATIONS, LLC™

Welcome

Patient Medical and Dental History

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

How did you hear about us?_____

Name:_____

Date:_____ Soc. Sec#:_____

Birthday:_____ Home Phone:_____ Cell Phone:_____

Patient email:_____

Address, City, State, Zip:_____

Preferred contact method for appointment reminders: Email Phone call Mail

Circle Appropriate: Single Married Divorced Widowed

Patient's Employer:_____Work Phone:_____

Spouse's Name:_____

Employer:_____Work Phone:_____

Person to contact in case of emergency:_____Ph:_____

Insurance Information

Name of insured:_____ Guarantor SSN:_____

Relationship to patient:_____ Guarantor Birthday:_____

Insurance Company:_____ Group#:_____

Medical Information

1) Physician:_____

Office phone:_____ Date of Last Exam:_____

2) Are you under medical treatment now?_____
If yes, please explain:_____
_____

3) Are you taking any medications, prescriptions or non-prescriptions?_____
If yes, please explain:_____
_____

4) Are you allergic to or have had any reaction to any medication or substance?_____
_____
_____

5) Do you smoke or use smokeless tobacco?_____
Have you ever smoked or used smokeless tobacco? Yes No
If yes, indicate how much and how often:_____

6) Do you consume alcohol? Yes No
If yes, please indicate how much and how often:_____

7) Women: Are you Pregnant? Yes_____ months No
Nursing? Yes No

8) Do you have or have you had any disease, conditions, or problems not listed?_____
If yes, please explain:_____
_____

9) Do you have or have you had any of the following? Please circle "Yes" or "No".

Heart (surgery, disease, attack)	Yes	No	Respiratory Problems	Yes	No
			Emphysema	Yes	No
Chest Pain	Yes	No	Asthma	Yes	No
High Blood Pressure	Yes	No	Liver Disease	Yes	No
Mitral Valve Prolapse	Yes	No	Hepatitis / Jaundice	Yes	No
Heart Murmur	Yes	No	Thyroid Problems	Yes	No
Stroke	Yes	No	Kidney Problems	Yes	No
Arthritis / Rheumatism	Yes	No	Diabetes	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Diet (special/restricted)	Yes	No
			AIDS or HIV infection	Yes	No
Sinus Trouble / Allergies	Yes	No	Cancer	Yes	No
Latex Sensitivity	Yes	No	Tumors	Yes	No

Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Chemotherapy	Yes	No	Nervous / Anxious	Yes	No
Frequent Headaches	Yes	No	Psychiatric/Psychological		
Neurological Disorders	Yes	No	Care	Yes	No
Epilepsy or Seizures	Yes	No			

Dental Information

1.) Whom may we thank for referring you?_____

2.) What is the reason for your visit today?_____

3.) What are your present dental problems?_____

4.) Date of last dental visit:_____ Last dental cleaning:_____

Last dental X-ray:_____

5) Do you have any sores or lumps in or near your mouth?_____
If yes, please explain:_____
_____

6.) Have you had any head, neck or jaw injuries?_____
If yes, please explain:_____
_____
_____

Please circle Yes or No.

7.) Do you clench or grind your teeth?	Yes	No
8.) Do you bite your lips or cheeks frequently?	Yes	No
9.) Have you ever experienced any of the following problems in your jaw?	Yes	No
• Clicking or Popping	Yes	No
• Difficulty in opening or closing	Yes	No
• Pain (joint, ears, or side of face)	Yes	No
10.) Do your gums bleed while brushing or flossing?	Yes	No
11.) Are your teeth sensitive to hot or cold liquids or foods?	Yes	No
12.) Are your teeth sensitive to sweet or sour liquids or foods?	Yes	No
13.) Do you have any pain in any teeth?	Yes	No
14.) Have you noticed any mouth odors or bad tastes?	Yes	No
15.) Have you noticed any loose teeth or changes in your bite?	Yes	No
16.) Have you ever had periodontal treatment?	Yes	No
17.) Are you satisfied with your teeth's appearance?	Yes	No

18.) Do you feel nervous about having dental treatment? Yes No

If yes, what is your biggest concern?_____

_____

I understand the above information is necessary to provide dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the receptive health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

_____

Patient/ Guardian Signature ***Date***