Jen-Kuei Wang, Ph.D, D.D.S.
Office: 408.245.8822
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PATIENT INFORMATION FORM

Patient Name: _____

Birth Date: _____ **Social Security** #: _____

Home Address: _____

City: _____**State:** _____ **Zip:** _____

Home#( ) _____ **Cell#**( )_____

Email: _____

Whom should we contact in case of an Emergency: _____

Phone: ( ) _____

Relationship to Patient: _____

General Dentist's Full Name: _____ **Phone: ( )**_____

Primary Dental Insurance:

Name of Insurance Co: _____

Name of Subscriber: _____

Relation of Subscriber to Patient: _____

Subscriber Employer : _____

Subscriber / Employee ID# / SSN : _____

Group #: _____

Birth Date of Subscriber: _____

Secondary Dental Insurance:

Name of Insurance Co: _____

Name of Subscriber: _____

Relation of Subscriber to Patient: _____

Subscriber Employer : _____

Subscriber / Employee ID# / SSN : _____

Group #: _____

Birth Date of Subscriber: _____

We need the above information so that we can help obtain the dental insurance benefits you are eligible for. This may require submitting the Doctor's treatment plan to the insurance company(s) for a **pre-determination** of benefits, or in some cases obtaining the information by phone and internet. We can ***NEVER*** guarantee payment by your insurance company. The insurance company's contract is with you and your employer.

Policies and Procedure

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I certify the information on the Patient Information Form is true and correct to the best of my knowledge. I will notify the office of Dr. Jen-Kuei Wang and Dr. Midori Tachibana of any changes in my health status or any changes in the above information.

I authorize routine dental diagnostic procedures. If I accept the proposed treatment plan, I also agree to the use of local anesthetics and pre-medications considered necessary or advisable by the doctor for my comfort and well being.

Signature of Patient/Guardian: _____Date: _____

Dental History

Do you presently have a toothache? _____ Yes No
If the tooth in question has had a root canal already, how long ago was it done? _____ Yes No
Have you had a history of swelling associated with this area? _____ Yes No
Is any part of your mouth sensitive to Hot, Cold, Biting/ Pressure? (please circle if yes) Yes No
Have you ever had an adverse reaction to local anesthetics? _____ Yes No
Have you ever had trouble getting numb? _____ Yes No

Medical History

Are you currently under a physician's care? If yes, why_____ Yes No
Have you ever been hospitalized or had a major operation? _____ Yes No
Have you ever had a serious injury to your head or neck? _____ Yes No
Have you ever been instructed by an MD to premedicate before dental appts?_____ Yes No
Have you ever received radiation therapy to the jaw or head and neck region?_____ Yes No
Have you ever taken Fen-Phen (anti-obesity treatment drug)? _____ Yes No
Have you ever or are you now taking any of the following? (please circle)
Zometa, Aredia, Fosamax, Actonel, Didronel, Skelid, Boniva. Bonefos, or Ostec?
Aspirin, Baby Aspirin, Plavix, or Coumadin?

Are you Allergic to any of the following?: YES or NO (If yes, please mark or list which one)
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Other _____

Women Please check:
☐ Pregnant ? In what month are you in your pregnancy? _____
☐ Trying to get pregnant ☐ Nursing ☐ Taking birth control
Note: Antibiotics may interfere with the effectiveness of oral contraceptives.

Please list all medications being taken at this time (please include any herbal supplements):

_____ _____ _____

_____ _____ _____

Please Check Yes or No **(NOTE: IT IS REQUIRED THAT YOU READ AND CHECK EITHER THE YES OR NO BOX INDIVIDUALLY! NO VERTICAL LINES THROUGH THE ROWS)**

Yes	No		Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Diabetes	☐	☐	Bruise Easily	☐	☐	Emphysema	☐	☐	Liver Disease	☐	☐	Cold Sores
☐	☐	Heart Surgery/ Stroke	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐	Kidney Problems	☐	☐	Herpes
☐	☐	Heart Murmur	☐	☐	Excessive Bleeding	☐	☐	Cancer	☐	☐	Renal Dialysis	☐	☐	Venereal Disease
☐	☐	Angina/ Chest Pain	☐	☐	Sickle Cell Disease	☐	☐	Radiation	☐	☐	Thyroid Disease	☐	☐	HIV Positive
☐	☐	Heart Attack/ Failure	☐	☐	Recent Blood Transfusion	☐	☐	Chemotherapy	☐	☐	Parathyroid Disease	☐	☐	AIDS
☐	☐	Rheumatic Fever	☐	☐	Leukemia	☐	☐	Stomach/Intestinal Disease	☐	☐	Arthritis/Gout	☐	☐	Genital Herpes
☐	☐	Mitral Valve Prolapse	☐	☐	Asthma	☐	☐	Ulcers	☐	☐	Artificial Joint	☐	☐	Headaches/ Migraines
☐	☐	Artificial Heart Valve	☐	☐	Chronic Sinusitis	☐	☐	Recent Weight Loss	☐	☐	Psychiatric Care	☐	☐	Glaucoma
☐	☐	High Blood Pressure	☐	☐	Lung Disease	☐	☐	Hepatitis A	☐	☐	Epilepsy or Seizures	☐	☐	Tumors or Growths
☐	☐	Low Blood Pressure	☐	☐	Breathing Problems	☐	☐	Hepatitis B or C	☐	☐	Fainting or Dizziness	☐	☐	Nervousness

Have you ever had any other serious illness not checked above? (Yes / No) _____

To the best of my knowledge, all preceding answers are correct. If I have any changes in my health status or if my medicines change, I will inform the dentist and staff at my next appointment without failure.

X_____ DATE_____ Reviewed by Doctor_____ DATE_____
PATIENT'S SIGNATURE (PARENT OR GUARDIAN) DOCTOR'S SIGNATURE

Medical Updates

I have read my MEDICAL HISTORY dated _____and I confirm that it adequately states past and present conditions

DATE	CHANGES		PATIENT'S SIGNATURE	REVIEWED BY DOCTOR
_____	_____	NO CHANGES	_____	_____
_____	_____	NO CHANGES	_____	_____
_____	_____	NO CHANGES	_____	_____
_____	_____	NO CHANGES	_____	_____