Bing Elliot Xia DDS

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Whom May We Thank for Referring You? Friend/Relative (name):____________________________ *S.F. Examiner*, *SF Weekly*, *Chinese Yellow Pages*, *Singtao Yellow Pages*, Direct Mail, Chinese TV, Chinese Radio, Internet Google / Yahoo / CitySearch, *Singtao Newspaper*, *World Journal*, *AT&T Pacific Bell Yellow Pages*, Postcard, Other__________________________________

Getting To Know You

First Name_________________ Last Name_______________
Gender: ________ Date of Birth ________________________
If the patient is a child, Parent's Name___________________

Marital Status__________ SS#__________________________
Street Address____
City______________________ State ______Zip____________

Home Phone #_________________ Cell #________________
Work #_______________
Email Address____
Employer /Address ____________________________________

Previous Dentist______________________________________
Last Visit Date_________________________

Spouse's Information

Spouse's Name ___________________ Birth date: _________
SS#______________________ Work #___________________
Employer /Address ____________________________________

Emergency Information

Nearest Relative (not living with you) ___________________
Phone #__________________ Work #___________________

Account Responsible Party:

Name: __________________________ Relationship________

Primary Dental Insurance

Insurance Company Name______________________________
Phone # _______________________ Group # ____________

Insured's Name_____________________ Relation__________
Insured's Birth date ______________ SS#_________________
Contact Phone #: _______________________
Employer____
Date Insurance Policy was Started_______________________

Secondary Dental Insurance

Insurance Company Name______________________________
Phone #: _________________ Group #:__________________

Insured's Name _________________Relation_____________
Insured's Birth date ______________ SS#_________________
Contact Phone #: __________________________
Employer____
Date Insurance Policy was Started_______________________

Authorization

I authorize and give consent to the performance of dental services for myself or my dependent. I give consent to any necessary or advisable dental procedures, medications, or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposes or dental treatment. I understand that using anesthetic agents embodies certain risks. I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am finally responsible for payment of services rendered, regardless of insurance coverage.

Patient/Guardian Signature ____ Date_____________________________

I hereby acknowledge that I have received copies of the following notices: The Dental Board of California Dental Materials Fact Sheet, and the HIPPA Privacy Form 1 Notice of Privacy Practices.

Patient / Guardian Signature____ Date_____________________________

Health History

I Circle Appropriate Answer

1. Yes No Is your general health good? Date of your last medical exam: ______________________________
2. Yes No Has there been a change in your health within the last year? Date of your last medical exam_______________
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   YES, why? ____
4. Yes No Are you being treated by a physician now? For what?____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. Have you experienced:

1. Yes No Chest pain (angina)
2. Yes No Swollen ankles
3. Yes No Shortness of breath
4. Yes No Recent weight loss, fever, night sweats?
5. Yes No Persistent cough, coughing up blood
6. Yes No Bleeding problems, bruising easily
7. Yes No Sinus problems
8. Yes No Difficulty swallowing
9. Yes No Diarrhea, constipation, blood in stools
10. Yes No Excessive thirst
11. Yes No Frequent urination
12. Yes No Frequent vomiting, nausea
13. Yes No Difficulty urinating, blood in urine
14. Yes No Dizziness
15. Yes No Ringing in ears
16. Yes No Headaches
17. Yes No Fainting spells
18. Yes No Blurred vision
19. Yes No Seizures
20. Yes No Joint pain, stiffness
21. Yes No Dry mouth
22. Yes No Jaundice

III. Do You Have or Have You Had:

1. Yes No Heart disease
2. Yes No Stroke, hardening of arteries
3. Yes No High blood pressure
4. Yes No Asthma, TB, emphysema, other lung diseases
5. Yes No Hepatitis or other liver diseases
6. Yes No Stomach problems, ulcers?
7. Yes No **Allergies to:** ________________________________
   drugs, foods, medication, latex
8. Yes No Family history of diabetes, heart problems
9. Yes No AIDS
10. Yes No Cancer, tumors
11. Yes No Arthritis, rheumatism
12. Yes No Eye diseases
13. Yes No Prosthetic heart valve
14. Yes No Hospitalization
15. Yes No Surgeries
16. Yes No Contact lenses
17. Yes No Thyroid, adrenal disease
18. Yes No Heart attack, heart defects
19. Yes No STD (syphilis or gonorrhea)
20. Yes No Kidney, bladder disease
21. Yes No Skin diseases
22. Yes No Diabetes
23. Yes No Psychiatric care
24. Yes No Radiation treatment
25. Yes No Herpes
26. Yes No Anemia
27. Yes No Rheumatic fever
28. Yes No Heart murmurs
29. Yes No Artificial joint
30. Yes No Blood transfusions
31. Yes No Pacemaker
32. Yes No Chemotherapy

IV. Are You Taking:

1. Yes No Recreational drugs
2. Yes No Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies
3. Yes No Tobacco in any form
4. Yes No Alcohol

Please list: ____

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V. Women Only:

1. Yes No Are you or could you be pregnant or nursing
2. Yes No Taking birth control pills

VI. All Patients:

1. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain: ____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's / Guardian Signature: ____ **Date:** __________________________

RECALL REVIEW:

1. **Patient's / Guardian Signature** ____________________________________ **Date:**__________________________
2. **Patient's / Guardian Signature** ____________________________________ **Date:**__________________________