

Dayton Q.L. Lum D.D.S., Inc.
803 Kamehameh Highway, Suite 401
Pearl City, Hawaii 96782
Phone: 456-5005 Fax: 455-5099

Welcome -- A warm thank you for having confidence in us to help you in maintaining your dental health. Please kindly provide us with some important information to help us get to know you better. Thank you.

Personal Data:

Name _____ M _____ F _____
Date of Birth ___/___/___ SSN _____ - _____ - _____
Address _____ Zip _____
Telephone: Business _____ Home _____ Cel/Pgr. _____
Preferred Contact No. _____
Occupation _____ Employer/School _____
Employer's Address _____ Zip _____
Who may we thank for referring you to our practice? _____

Emergency Contact: Name _____
Phone No. _____ Relationship _____

Financial Data:

Person Responsible for Account _____
Address _____ Zip _____
Telephone: Business _____ Home _____

Dental Insurance:

Subscriber's Name _____
Subscriber's Date of Birth ___/___/___ SSN _____ - _____ - _____
Insurance Company _____ Policy No. _____
Employer _____ Dental Union/Group _____
For Military Dependents - Subscriber's Rank _____

IMPORTANT: Please be knowledgeable about your insurance benefits. We are happy to assist you with any questions regarding benefits or eligibility. You are responsible for the full payment of any treatment or service not covered by your insurance.

Medical & Dental History: So that we are able to provide you with complete and appropriate dental care, please provide us with the following information. Please fee free to ask about any question(s) you may not understand. Thank you.

Previous Dentist _____ Phone No. _____
Address _____ Zip _____
Date of Last Visit ___/___/___ Purpose: Emergency _____ Regular Care _____
Current Concerns or Questions _____
Name of Physician _____ Phone # _____
Address _____ Zip _____
Date of Last Exam ___/___/___ Operations/Complications _____

Are you taking any of the following? (Please answer **yes or no**):

- | | |
|--|---|
| <input type="checkbox"/> Antibiotics or sulfa drugs | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Anticoagulants (blood thinners) | <input type="checkbox"/> Insulin (or similar drug) |
| <input type="checkbox"/> Medications for High Blood Pressure | <input type="checkbox"/> Medication for heart trouble |
| <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Digitalis, Nitroglycerin |
| <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Hormonal Therapy or BC |
| <input type="checkbox"/> Cortisone (steroids) | Other _____ |

Do you have a medical history of any of the following diseases or conditions? (Please answer **yes or no**):

- | | | |
|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Kidney/Liver Problems | <input type="checkbox"/> Hepatitis A,B or C | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Asthma | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> High or Low B.P. |
| <input type="checkbox"/> HIV+ | <input type="checkbox"/> AIDS | |
| <input type="checkbox"/> Other (What condition? _____) | | |

Are you allergic to any of the following? (Please answer **yes or no**)

- | | | |
|---|----------------------------------|--|
| <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Iodine | <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Valium | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Codeine | <input type="checkbox"/> Nitrous Oxide |
| <input type="checkbox"/> Mercury | <input type="checkbox"/> Latex | Other _____ |
| <input type="checkbox"/> Barbiturates, Sedatives
or Sleeping Pills | | |

Please answer the following questions **yes or no**:

1. Do you consider yourself in good health? _____
2. Do you smoke? _____
3. Are you now under the care of a physician? _____ If so, what is the condition being treated? _____
4. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? _____ a. Do you bruise easily? _____ b. Have you every required a blood transfusion? _____ If so, please explain the circumstances _____
5. Have you had surgery or x-ray treatment for a tumor, growth or other condition of the head and neck? _____
6. Have you had any serious trouble associated with previous dental treatment? _____
7. Do you have any disease, condition or problem not listed that we should know about? _____ If so, what? _____
8. Are you wearing contact lenses? _____
9. Do any of your teeth hurt? _____
10. Do your gums bleed? _____
11. Do you have recurring cold sores? _____
12. Do you have "tension" headaches or earaches? _____
13. If you have missing teeth, do you know it is important to replace them? _____

- 14. Have you ever had correct brushing and flossing instructions? _____
- 15. Are your teeth sensitive to hot and/or cold? _____
- 16. Do you object to having gold fillings in your mouth? _____

WOMEN:

- 17. Are you pregnant? _____ If so, how many weeks? _____
- 18. Do you have any problems associated with your menstrual period? _____
- 19. Are you nursing? _____

CONSENT:

The undersigned hereby authorizes the Doctor to take radiographs, study models, photographs or any other diagnostic aid deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk.

I understand that payment for dental service provided in this office for myself and my dependent(s) is due and payable at the time dental services are rendered.

I understand that it is my responsibility to notify the Doctor or his staff in the event that I am unable to keep any appointment. There will be no charge for canceled appointments if notification is received 48 hours prior to the appointment date. A charge will be assessed for any missed appointment or if cancellation is received less than 48 hours in advance.

Print Name: _____

Signature: _____ Date: ___/___/___

(Signature of Parent or Guardian if patient is less than 18 years of age.)

Insurance Release

SIGNATURE AUTHORIZATION FORM:

I have reviewed the following treatment plan. I authorize the release of any information relative to this claim.

_____/_____/_____
Signature (Patient or Parent/Guardian if minor) Date

I hereby authorize payment of my group insurance benefits, otherwise payable to me, to the dentist. (This authorization applies only to non-participating dentists.) Claim payments are mailed directly to participating dentists.

_____/_____/_____
Signature (Insured Person) Date