



Woo Jang, DDS

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PATIENT HISTORY FORM

Name (Last, First, MI)		Date	
Nickname	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Date of Birth	Age:	Social Security #	Drivers License #
Address (Street, City, State, Zip)			
Email Address		Whom may we thank for referring you?	
Home Phone	Work Phone	Cell Phone	
Occupation	Full-/Time Student: <input type="checkbox"/> Yes <input type="checkbox"/> No		If so, where:

PERSON RESPONSIBLE FOR THE ACCOUNT/INSURED PARTY

Legal Name (Last, First, MI)		Date of Birth	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, City, State, Zip)			
Home Phone:	Work Phone:	Cell Phone:	
Social Security #:	Relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other		
Employer:	Drivers License #		
Employer Address:			
Primary Insurance Company:			
Name of Insured:		Insured ID #	
Insurance Phone:	Policy #	Group #	
Secondary Insurance Company:			
Name of Insured:		Insured ID #	
Insurance Phone:	Policy #	Group #	

Authorization: I hereby consent to the taking of x-rays, photographs, and other necessary records before, during, and after treatment and to the use of same by this practice for scientific paper demonstrations. I authorize Pinnacle Dental to furnish information to the insurance carrier concerning treatment rendered. I hereby assign to Pinnacle Dental all payments from services rendered. I understand that I am fully responsible for payment of all charges incurred.

Patient (or Legal Guardian) Signature

Date

HEALTH QUESTIONNAIRE

Physician's Name	Phone	Last Physical Exam
Address	Pharmacy	Phone
Emergency Contact	Phone	Relationship
Address		

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING

	Yes	No	When		Yes	No	When
Very high fever with disease as a child	<input type="checkbox"/>	<input type="checkbox"/>		Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>		Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	
Congenital heart disease	<input type="checkbox"/>	<input type="checkbox"/>		Nervous disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Heart valve damage	<input type="checkbox"/>	<input type="checkbox"/>		Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	
Heart valve replacement	<input type="checkbox"/>	<input type="checkbox"/>		Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>	
Mitral valve prolapse, Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>		Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>	
Chest pain (Angina)	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
High/Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>		High/Low blood sugar	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>		Anemia	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>		Other blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis or other lung disease	<input type="checkbox"/>	<input type="checkbox"/>		Abdominal bleeding from cut	<input type="checkbox"/>	<input type="checkbox"/>	
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>		AIDS/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>		Back injury	<input type="checkbox"/>	<input type="checkbox"/>	
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>		Back pain	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>		Tumor	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling of ankles	<input type="checkbox"/>	<input type="checkbox"/>		Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>		Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	
Faint easily	<input type="checkbox"/>	<input type="checkbox"/>		Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	
Lymphatic disease	<input type="checkbox"/>	<input type="checkbox"/>		Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Hip, knee or any joint replacement	<input type="checkbox"/>	<input type="checkbox"/>		Allergic to penicillin	<input type="checkbox"/>	<input type="checkbox"/>	
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>		Allergic to codeine	<input type="checkbox"/>	<input type="checkbox"/>	
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>		Allergic to local anesthetic	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>		Allergic to aspirin	<input type="checkbox"/>	<input type="checkbox"/>	
Other liver disease	<input type="checkbox"/>	<input type="checkbox"/>		Allergic to metal (jewelry)	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>		Allergic to latex	<input type="checkbox"/>	<input type="checkbox"/>	

List medications you are allergic to:

LIST ALL MEDICATIONS, HERBAL SUPPLEMENTS, OR DRUGS YOU ARE NOW

Name of Drug	How often each day	Purpose or disease treated

Do you smoke? Yes No If so, how many packs per day? _____

Use alcohol? Yes No If so, how much per day? _____

Do you now or have you ever used tranquilizers? Yes No

Have you ever been treated with cortisone or steroid drugs? Yes No

Have you ever been treated in the hospital or had any surgery? Yes No

Are you now or have you been pregnant? Yes No

Nursing? Yes No

Are you currently taking oral contraceptives? Yes No

Are you under the care of a physician now? Yes No

Have you ever taken Fen/Phen? Yes No

Have you had any problems with dental treatments? Yes No

COMMENTS:

I, _____ attest that the above information is accurate and complete.

Patients Signature	Reviewed	Date
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