Woo Jang, DDS • 6313 Preston Road, Suite 100 • Plano, Texas 75024 • (972)801-2788 • PinnacleDDS.com

PATIENT HISTORY FORM

Name (Last, First, MI)			Date
Nickname	Sex: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ 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: ☐ Yes ☐ No	If so, where:	

PERSON RESPONSIBLE FOR THE ACCOUNT/INSURED PARTY

Legal Name (Last, First, MI)		Date of Birth	Sex: ☐ Male ☐ Female
Address (Street, City, State, Zip)			
Home Phone:	Work Phone:	Cell Phone:	
Social Security #:	Relationship to patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ 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	☐	☐		Stroke	☐	☐	
Rheumatic fever	☐	☐		Glaucoma	☐	☐	
Congenital heart disease	☐	☐		Nervous disorder	☐	☐	
Heart valve damage	☐	☐		Kidney problems	☐	☐	
Heart valve replacement	☐	☐		Excessive urination	☐	☐	
Mitral valve prolapse, Heart murmur	☐	☐		Excessive thirst	☐	☐	
Chest pain (Angina)	☐	☐		Diabetes	☐	☐	
High/Low blood pressure	☐	☐		High/Low blood sugar	☐	☐	
Seizures	☐	☐		Anemia	☐	☐	
Asthma	☐	☐		Hemophilia	☐	☐	
Pneumonia	☐	☐		Other blood disorder	☐	☐	
Tuberculosis or other lung disease	☐	☐		Abdominal bleeding from cut	☐	☐	
Bronchitis	☐	☐		AIDS/HIV Positive	☐	☐	
Hay fever	☐	☐		Back injury	☐	☐	
Sinus trouble	☐	☐		Back pain	☐	☐	
Thyroid problems	☐	☐		Tumor	☐	☐	
Swelling of ankles	☐	☐		Cancer	☐	☐	
Shortness of breath	☐	☐		Syphilis	☐	☐	
Faint easily	☐	☐		Gonorrhea	☐	☐	
Lymphatic disease	☐	☐		Allergies	☐	☐	
Hip, knee or any joint replacement	☐	☐		Allergic to penicillin	☐	☐	
Ulcers	☐	☐		Allergic to codeine	☐	☐	
Jaundice	☐	☐		Allergic to local anesthetic	☐	☐	
Hepatitis	☐	☐		Allergic to aspirin	☐	☐	
Other liver disease	☐	☐		Allergic to metal (jewelry)	☐	☐	
Arthritis	☐	☐		Allergic to latex	☐	☐	

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 crtisone 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