JOSHUA HONG DDS
cosmetic & restorative dentistry

Patient Information

☐ Single ☐ Married ☐ Divorced ☐Widowed ☐ Minor

Name_____ Preferred Name_____

SS#_____ Date of Birth_____Age_____ ☐ Male ☐ Female

Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Email_____

Referred by_____

Insurance Information

Insurance Co._____ Insurance Phone_____

Policyholder Name_____ DOB_____

Policyholder SS/ID#_____ Group #_____

Employer_____

I'd like to talk to Dr. Hong about:

☐ **Getting Rid of Discomfort** ☐ **Teeth Whitening** ☐ **TMJ Treatment** ☐ **Cosmetic Dentistry**

☐ **All-on-Four/Implants** ☐ **Full Mouth Reconstruction** ☐ **Veneers** ☐ **Orthodontia**

☐ **Organic/All-Natural Dental Care** ☐ **Celebrity Smile**

As a courtesy Joshua Hong DDS will work with your insurance carrier to the best of our ability. However, we are not experts at your insurance coverage and benefits, nor do any of the team members work for your insurance company. Therefore, we encourage all our clients to be as familiar as possible with your coverage and benefits so that we can work together as a team to utilize your insurance to the best of our ability. Ultimately if we miss something it is your responsibility financially. Likewise, if your insurance fails to pay it is also your financial responsibility. So please be aware and double check the information we provide you. We are not your insurance company and choose to work with your insurance as a courtesy to you. Let's work as a team.

Medical History

Please answer all questions by circling Yes or No

Are you currently in good health? Yes or No

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

If yes, what condition are you being treated for?
_____
_____
_____
_____

Physician Name_____
Physician Phone_____

Have you ever been hospitalized or had a serious illness? Yes or No
If Yes, please explain_____
_____
_____

Do you use tobacco in any form? Yes or No
If Yes, how what and how much_____

Do you use alcoholic beverages (+2 drinks/day)? Yes or No

Women: Are you Pregnant or chance of pregnancy? Yes or No
If Yes, please provide due date_____
Are you currently nursing? Yes or No

Are you ALLERGIC or experienced any adverse reaction to the following?

Local Anesthetics (Novocain)	Yes or No	Latex	Yes or No
Penicillin	Yes or No	Codeine	Yes or No
Other Antibiotics	Yes or No	Aspirin	Yes or No

Other Allergies Not Listed (please list) or write N/A:_____
Are you taking any medications? Please list name, dosage, and reason or write N/A:
_____
_____
_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or medication, I will inform the dentist at my next appointment.

_____
Signature of Client or Guardian Date

Do you have or have you ever had any of the following?

Headaches	Yes or No	Hay Fever	Yes or No
Rheumatic Fever	Yes or No	Sinus Trouble	Yes or No
Frequent Nose Bleeds	Yes or No	Allergies/Hives	Yes or No
Tire easily	Yes or No	Diabetes	Yes or No
Bruise easily	Yes or No	Thyroid Disease	Yes or No
Tumors or Growths	Yes or No	X-Ray or Cobalt Treatment	Yes or No
Prolonged Bleeding	Yes or No	Chemotherapy	Yes or No
Cancer	Yes or No	Arthritis	Yes or No
Chest pain/discomfort	Yes or No	Rheumatism	Yes or No
Shortness of breath	Yes or No	Glaucoma	Yes or No
Swelling of ankles	Yes or No	Pain in Jaw Joints	Yes or No
Radiation Treatment	Yes or No	Aids/HIV	Yes or No
Heart Attack/Disease	Yes or No	Hepatitis_____	Yes or No
Congenital Heart Defect	Yes or No	Liver Disease	Yes or No
Artificial Heart Valve	Yes or No	Jaundice	Yes or No
Pacemaker	Yes or No	Blood Transfusion	Yes or No
Heart Surgery	Yes or No	Drug Addiction	Yes or No
Heart Murmur	Yes or No	Hemophilia	Yes or No
Stroke	Yes or No	Venereal Disease/STD	Yes or No
Artificial Joint	Yes or No	Cold Sore	Yes or No
Angina	Yes or No	Genital Herpes	Yes or No
High Blood Pressure	Yes or No	Epilepsy/Seizures	Yes or No
Heart Murmur	Yes or No	Fainting/Dizziness	Yes or No
Scarlet Fever	Yes or No	Nervousness	Yes or No
Anemia	Yes or No	Psychiatric Treatment	Yes or No
Kidney Disease	Yes or No	Tuberculosis (TB)	Yes or No
Asthma	Yes or No	Cough	Yes or No
Ulcers	Yes or No	Emphysema	Yes or No

Please note any other diseases or conditions not listed or write N/A:

_____

_____

_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or medication, I will inform the dentist at my next appointment.

_____

Signature of Client or Guardian Date