CLINICAL QUESTIONNAIRE FOR:

Stanley Cho, D.D.S., P.S.
John Clifford, D.D.S.
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Tom Wei, D.D.S., M.S.

PLEASE READ CAREFULLY

In order to obtain a complete survey of your particular dental needs, it is necessary to make a thorough visual and x-ray examination. Certain medical questions relating to dental treatment will also be asked. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. The best dental treatment is based on mutual understanding, and advanced discussion of your dental needs. If the purpose of your appointment is for emergency treatment only, a complete examination will be deferred until after emergency treatment is completed.

If you have dental insurance, be sure to answer those questions relating to dental insurance. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. Patients are responsible for knowledge of their insurance policy coverage. Patients are responsible for informing our office of any changes in their insurance policies or coverage. All dental services performed without previous financial arrangements, must be paid for in full at the time of service. Fee estimate listed for dental care can only be extended for a period of 3 months from the date of the patient's examination.

I authorize the release of any information concerning health care, advice and treatment to another dentist. I understand there may be a charge for any appointment that is not kept, or cancelled with less than 24 hours notice. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

Patient's Last Name
______________________ First______________________ Middle Initial______ Male____ Female____

Patient's Date of Birth___/___/___ Age___ Patient's SS#______________ Single___ Married___ Separated___ Divorced__

Spouse's Name____ Number of Dependants_______

Home Address______________________________ City____________ Zip___________ How Long?_________

Billing Address (if different)____

Home Phone (____)_____________ Cell Phone (____)_____________ Work Phone (____)_____________ Ext_______

Employer______________________________________ Email______________________________________

Person Responsible for Account____

Primary Insurance Information:

Insurance Plan__________________________________ Group#_____________ Subscriber ID#_______________

Subscriber's Name____ Birth Date_______________

Subscriber's SSN #____________________ Employer______________________________________

I authorize release of any information relating to dental claims. I understand that I am responsible for all costs of dental treatment.

☛ ____
Signed (Patient, or parent if minor) Date

I hereby authorize payment directly to Stanley Cho, DDS, PLLC of the group insurance benefits otherwise payable to me.

☛ ____
Signed (Patient, or parent if minor) Date

Secondary Insurance (if applicable):

Insurance Plan__________________________________ Group#_____________ Subscriber ID#_______________

Subscriber's Name____ Birth Date_______________

Subscriber's SSN #____________________ Employer______________________________________

Does your insurance have a deductible? ______________________________ How much?___________________

Nearest Relative____ Their home phone___________________

Referred by__________________________________ Most convenient appointment time_________________

I have read the above information and agree to the terms and conditions.

_______________ ____
Date Signature of Patient (Parent if patient is a Minor)

(Continued on Back)

DENTAL HISTORY

1. **Reason for visit / Main Concern?** Check-Up ❑ Cleaning ❑ Toothache ❑ Other ____________________________
2. Are there other conditions of which we should be aware? Yes ❑ No ❑ If yes, please specify:____________________
3. When did you last visit a dentist?__________________ 4. What treatment was performed? __________________
5. Was the treatment completed?__________________ 6. When were dental x-rays taken? __________________
7. Did you have a cleaning? Yes ❑ No ❑ 8. Have you had gum (periodontal) treatment? Yes ❑ No ❑
9. Have you ever had prolonged bleeding after an extraction? Yes ❑ No ❑ If yes, please specify:____________________
10. Have you had any problems with past dental treatment? Yes ❑ No ❑ If yes, please specify:____________________
11. Do you grind your teeth, clinch your jaws, or have symptoms near your ears such as clicking, popping, pain or locking open? Yes ❑ No ❑ If yes, please specify:____________________
12. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction, sometimes called TMJ? Yes ❑ No ❑ If yes, please specify:____________________
13. Do your gums bleed easily? Yes ❑ No ❑ 14. Do you feel you have bad breath? Yes ❑ No ❑
15. Are your teeth sensitive to hot or cold? Yes ❑ No ❑ 16. Would you like your teeth whiter? Yes ❑ No ❑
17. Are you happy with your smile? Yes ❑ No ❑ If no, please explain: ____________________

MEDICAL HISTORY

1. Are you under a Doctor's care at this time? Yes ❑ No ❑ If yes, please specify:______________Dr. Name______________ Dr. Phone____________________
2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine?________________
3. Are you taking any medications at this time, including birth control? Yes ❑ No ❑ If yes, please specify:________________
4. (Woman) Are you pregnant at this time? Yes ❑ No ❑ If yes, please specify how many months:____________________
5. Are there any other health problems of which we should be advised? Please specify:____________________
6. Do you have, **OR**, have you had, any of the following?

Please check "YES" or "NO"			Doctor's Comments
ARTIFICIAL Heart Valve	Yes ❑	No ❑	________
AIDS/HIV+	Yes ❑	No ❑	________
ANEMIA	Yes ❑	No ❑	________
ANGINA	Yes ❑	No ❑	________
ARTHRITIS	Yes ❑	No ❑	________
ASTHMA	Yes ❑	No ❑	________
BLEEDING PROBLEMS	Yes ❑	No ❑	________
CANCER	Yes ❑	No ❑	________
CHEM/RAD THERAPY	Yes ❑	No ❑	________
COSMETIC SURGERY	Yes ❑	No ❑	________
DEMENTIA	Yes ❑	No ❑	________
DIABETES	Yes ❑	No ❑	________
DIALYSIS	Yes ❑	No ❑	________
DIZZY SPELLS	Yes ❑	No ❑	________
DRUG ADDICTION	Yes ❑	No ❑	________
EMPHYSEMA	Yes ❑	No ❑	________
EPILEPSY	Yes ❑	No ❑	________
FAINTING	Yes ❑	No ❑	________
GLAUCOMA	Yes ❑	No ❑	________
HEART ATTACK	Yes ❑	No ❑	________
HEART SURGERY	Yes ❑	No ❑	________
HEART MURMUR	Yes ❑	No ❑	________
HEART PROBLEMS	Yes ❑	No ❑	________

Please check "YES" or "NO"			Doctor's Comments
HEPATITIS	Yes ❑	No ❑	________
HIGH BL. PRESSURE	Yes ❑	No ❑	________
JAUNDICE	Yes ❑	No ❑	________
JOINT REPLACEMENT	Yes ❑	No ❑	________
KIDNEY DISEASE	Yes ❑	No ❑	________
LATEX ALLERGY	Yes ❑	No ❑	________
LIVER PROBLEMS	Yes ❑	No ❑	________
LOW BL. PRESSURE	Yes ❑	No ❑	________
LUNG DISEASE	Yes ❑	No ❑	________
ORGAN TRANSPLANT	Yes ❑	No ❑	________
PACEMAKER	Yes ❑	No ❑	________
PHEN-FEN	Yes ❑	No ❑	________
PSYCHIATRIC CARE	Yes ❑	No ❑	________
RHEUMATIC FEVER	Yes ❑	No ❑	________
SINUS TROUBLE	Yes ❑	No ❑	________
SLEEP APNEA	Yes ❑	No ❑	________
STROKE	Yes ❑	No ❑	________
THYROID PROBLEMS	Yes ❑	No ❑	________
TMD OR TMJ	Yes ❑	No ❑	________
TOBACCO USE	Yes ❑	No ❑	________
TUBERCULOSIS	Yes ❑	No ❑	________
VENEREAL DISEASE	Yes ❑	No ❑	________

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. I further certify that I consent to taking x-rays and an oral examination.

Patient's signature ______________________________ Date ______________
(Parent if Patient is a Minor)

Doctor's signature ______________________________

MEDICAL UPDATE:

1. Patient's signature__________________ Doctor's signature __________________ Date: __________
2. Patient's signature__________________ Doctor's signature __________________ Date: __________
3. Patient's signature__________________ Doctor's signature __________________ Date: __________