Ellis C. Wong D.D.S. Inc

drelliswong.com elliswongdds@gmail.com

607 North Larchmont Blvd • Los Angeles, CA 90004 (323)464-5555

Medical & Dental History Form

Patient Name: _____ _____ ___ _____

Last First MI Preferred Name

Would you consider yourself to be in fairly good health? ◯ Yes ◯ No

Has there been a change in your health within the last year? ◯ Yes ◯ No

Have you gone to the hospital or emergency room or had a serious illness within the last 3 years? ◯ Yes ◯ No

Are you being treated by a physican now? If Yes, please explain

_____

_____

Have you experienced any of the following? Please mark to indicate Yes in response to the question:

☐ Bleeding problems?	☐ Blood in urine/or stool?	☐ Blurred vision?	☐ Bruise easily?
☐ Chest pain (angina)	☐ Coughing up blood	☐ Diarrhea or constipation	☐ Difficulty swallowing
☐ Difficulty urinating	☐ Dizziness	☐ Dry mouth	☐ Excessive thirst
☐ Fainting spells	☐ Fever	☐ Frequent urination	☐ Frequent vomiting
☐ Headaches	☐ Jaundice	☐ Joint paint or stiifness	☐ Night sweats
☐ Persistent cough	☐ Recent significant weight loss	☐ Ringing in ears	☐ Shortness of breath
☐ Sinus problems	☐ Swollen ankles		

If any of the previous questions are marked, please explain:

_____

_____

Have you had any of the folllowing? Please mark to indicate Yes in response to the question:

☐ Bleeding problems	☐ AIDS/HIV	☐ Anemia	☐ Arthritis, rheumatism
☐ Atrificial joint	☐ Asthma	☐ Canker or cold sores	☐ Chemotherapy
☐ Cosmetic surgery	☐ Diabetes	☐ Eating disorders	☐ Emphysema or other Lung disease
☐ Eye disease	☐ Family history of Diabetes	☐ Family history of Heart disease	☐ Hardening of arteries
☐ Heart attack	☐ Heart defects	☐ Heart disease	☐ Heart murmurs
☐ Hepatitis	☐ Herpes	☐ High blood pressure	☐ Hospitalization
☐ Kidney or bladder disease	☐ Liver disease	☐ Osteoporosis	☐ Psychiatric care
☐ Radiation	☐ Rheumatic fever	☐ Seizures	☐ Sexual Trasnmitted disease
☐ Skin disease	☐ Stomach issues or ulcers	☐ Stroke	☐ Surgeries
☐ Thryoid disease	☐ Transplants	☐ Tuberculosis	☐ Tumors or Cancer

Are you allergic to or have you had a reaction to any of the following?

☐ Asprin	☐ Codeine	☐ Darvon
☐ Demerol	☐ Erythromycin	☐ Latex
☐ Local Anesthetic (Novacaine or Xylocaine)	☐ Metal	☐ Nitrous Oxide
☐ Penicillin	☐ Percodan	☐ Tetracycline
☐ Valium	☐ Vicodin	

Do you have any other health issues or allergies?

Are you taking or have you taken any of the following in the last three months?

- ☐ Alcohol
- ☐ Antibiotic
- ☐ Asprin
- ☐ Bisphonate (Fosamax)
- ☐ Over-the-counter Meds
- ☐ Recreational drugs
- ☐ Supplements
- ☐ Tobacco in any form
- ☐ Weight loss Meds

Please list ALL medicines you are currently taking:

Women Only

Could you be pregnant? ◯ Yes ◯ No

If Yes, what month:

Are you nursing? ◯ Yes ◯ No

Are you taking any form of birth control? ◯ Yes ◯ No

Please mark any of the following to indicate Yes in response to the question:

- ☐ Do your gums bleed when you brush or floss?
- ☐ Do your teeth experience sensitivity to cold or hot temperatures?
- ☐ Are any of your teeth currently causing you pain?
- ☐ Do you grind your teeth (either consciously or during sleep)?
- ☐ Are any of your teeth loose, or are you concerned about any teeth loosening?
- ☐ Do you currently have any dental implants, dentures, or partials?
- ☐ Have you ever been pre-medicated for dental treatment?
- ☐ Have you ever taken Fen-phen?
- ☐ Is there any issue or condition that you would like to discuss witht he dentist in private?

If any of the previous questions are marked, please explain:

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.**

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.
I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.
I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.
I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if

any).

Signature of patient, parent, or guardian:

Signature _____ **Date** _____

Relationship to Patient:

_____

_____

_____

Response Date: _____