LET'S GET ACQUAINTED

In order to serve you better, it is requested that you fill in the following information:

PATIENT INFORMATION:

Name _____ Nickname _____
Last First Middle

Social Security No._____ Birthdate___/___/___ Age _____

Driver's License No._____ Home Phone (___)_____

E-mail _____ Fax # (___)_____ Cell #(___)_____

Pager # (___)_____

Home Address _____ City_____ Zip_____

Marital Status ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed

Your Occupation _____ Employer _____

Business Address_____ City_____ Zip_____

Work Phone (___)_____ How long have you worked there?_____

Any hobbies?_____

Whom may we thank for referring you to our office? _____

IN AN EMERGENCY WE MAY CONTACT:

Nearest friend or relative _____ Phone (___)_____

Address_____ City_____ Zip_____

PERSON RESPONSIBLE FOR PAYMENT IF NOT THE SAME AS ABOVE.

Name _____ Relationship to patient_____

☐ My address and phone number is the same as above. (If different, please complete below.)

Address_____ City _____ Zip _____

Home phone (___)_____

Employer _____ Business Address _____

City_____ Zip_____ Work Phone (___)_____

INSURANCE INFORMATION:

PRIMARY CARRIER:

Name of insured _____ Social Security No. _____

Birth date ___/___/___ Name of Insurance Company_____

Group No. _____ Union Local No. _____ Group Plan Name _____

Address_____ City_____ Zip _____

If you have a second insurance carrier, please supply the following information:

Name of insured _____ Social Security No._____

Birth date___/___/___ Name of Insurance Company _____

Group No._____ Union Local No._____ Group Plan Name _____

Address_____ City_____ Zip_____

Raymond W. Lim, DDS

02/01

MEDICAL HISTORY:

Please circle Yes or No on any medical condition thay you had in the past or presently have:

Yes No Rheumatic Fever
Yes No Heart Murmur
Yes No Any Heart Problems
Yes No Artificial Heart Valve
Yes No Heart Pacemaker
Yes No Anemia
Yes No Blood Disease
Yes No Excessive Bleeding
Yes No High Blood Pressure
Yes No Arthritis
Yes No Thyroid Problems
Yes No Diabetes
Yes No Osteoporosis

Yes No Bisphosphonate Tx
Yes No Stroke
Yes No Epilepsy
Yes No Kidney Disease
Yes No Liver Disease
Yes No Tumor History
Yes No Venereal Disease
Yes No Allergies
Yes No Asthma
Yes No Glaucoma
Yes No Psychiatric Tx
Yes No Previous General Anesthesia

Yes No Faintness
Yes No Sinus Problems
Yes No HIV Positive
Yes No A.I.D.S
Yes No Autoimmune Disease
Yes No Cancer
Yes No X-ray or Radiation Treatment
Yes No Artificial Joints (Hips, knee, etc.)
Yes No Diet Pills
( ) Fen Phen

Yes No Hepatitis
( ) A (Infectious)
( ) B (Serum)
( ) C
Yes No Tuberculosis(TB)
Yes No Allergy To:
( ) Penicillin
( ) Aspirin
( ) Codeine
( ) Latex or rubber
( ) Dental Anesthetic
( ) Other Medication

( ) I have no medical problems listed above.

Any other medical condition not mentioned above: _____

What medications are you presently taking? _____

Physician's name or clinic _____ Specialty _____

Address _____ City _____ Zip _____

Phone No. ( ) _____

Women only: Are you pregnant? No ( ) Yes ( ) How many Months? _____

Are you taking birth control pills? No ( ) Yes ( )

Remarks _____

DENTAL HISTORY (PLEASE COMPLETE FULLY)

Name of former dentist or clinic _____ Phone number ( ) _____

Address _____ City _____ Zip _____

Date of last visit _____ Purpose of today's visit _____

What are your present goals for your teeth? _____

Any previous condition we should be aware of? _____

Remarks _____

CONSENT

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed necessary by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, use of anesthetic agents, medication and therapy, that may be indicated in connection with _____ (Name of Patient).

I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine and is due and payable at the time services are rendered (even if I have dental insurance) unless financial arrangements have been made with Doctor's office. I further understand that 1-1/2% finance charge (18% annual rate) will be added to any balance over 30 days. I also agree that in the event of default in the payment of any amount due,and if this account is placed in the hands of an agency for collection or legal action, to pay an additional charge equal to the cost of collection including bookkeeping, agency, and reasonable attorney fees and court costs incurred as permitted by laws governing these transactions.

I hereby authorize and direct my Insurance company to pay directly to Doctor any benefits that may accrue to me under my insurance plan.

_____ _____
Patient's Signature (Parent or Guardian if under 18) Date

_____ _____
Witness Date