Alan G. Chui, D.D.S., Inc.

1748 Novato Blvd., Suite 110
Novato, CA 94947
415-897-4884

Dental Registration and History

Name:_____ Email:_____

□Male □Female □Child

Social Security#:_____ Birth Date:_____

Home#:_____ Work#:_____ Cell#:_____

Address:_____

Street City State Zip Code

In case of emergency Name:_____ Phone#:_____

Whom may we thank for referring you?_____

Insurance Information of Self, Spouse or Responsible Party

Primary

Name of Insured:_____ Is insured a patient? □Yes □No

Last First MI

Insured's Birth Date:_____ ID#:_____ Group#:_____

Address:_____

Street City State Zip Code

Insured's Employer Name:_____

Address:_____

Street City State Zip Code

Patient's relationship insured:□ Self □Spouse □Child □Other_____

Insurance Plan Name and Address:_____

Secondary

Name of Insured:_____ Is insured a patient? □Yes □No

Last First MI

Insured's Birth Date:_____ ID#:_____ Group#:_____

Address:_____

Street City State Zip Code

Insured's Employer Name:_____

Address:_____

Street City State Zip Code

Patient's relationship insured:□ Self □Spouse □Child □Other_____

Insurance Plan Name and Address:_____

Consent for services/assignment and release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Alan G. Chui, D.D.S., Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions. I consent to the diagnostic procedures, including x-ray procedures and photographs, and treatment by the dentist necessary for proper dental care.

_____ Date:_____ Relationship:_____

Signature of patient, parent or guardian

Dental History

Name of Previous D.D.S.:_____ City/State:_____

Your last cleaning:_____ Your last x-rays:_____

Medical History

Medical Doctor's Name:_____ Date of last visit:_____
Medical Doctor's address and/or Phone Number:_____
Are you under a physician's care now? □Yes □No If yes_____
Have you ever been hospitalized or had a major operation? □Yes □No If yes_____
Have you ever had a serious head or neck injury? □Yes □No If yes_____
Are you taking any medications, pills, or drugs? □Yes □No If yes_____
_____
Do you take, or have you taken, Phen-Fen Redux? □Yes □No If yes_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? □Yes □No If yes_____
Are you on a special diet? □Yes □No If yes_____
Do you use tobacco? □Yes □No If yes_____

Women: Are you... □Pregnant/Trying? □Nursing? □Oral contraceptives?

Are you allergic to any of the following?

□Aspirin □Penicillin □Codeine □Acrylic □Metal □Latex □Sulfa □Local Anesthetics
Do you use controlled substances? □Yes □No If yes_____

Do you have, or have you had any of the following? (Please check if applies)

□AIDS/HIV Positive	□Cortisone Medicine	□Hemophilia	□Radiations Treatments
□Alzheimer's Disease	□Diabetes	□Hepatitis A	□Recent Weight Loss
□Anaphylaxis	□Drug Addictions	□Hepatitis B or C	□Renal Dialysis
□Anemia	□Easily Winded	□Herpes	□Rheumatic Fever
□Angina	□Emphysema	□High Blood Pressure	□Rheumatism
□Arthritis/Gout	□Epilepsy or Seizures	□High Cholesterol	□Scarlet Fever
□Artificial Heart Valve	□Excessive Bleeding	□Hives or Rash	□Shingles
□Artificial Joint	□Excessive Thirst	□Hypoglycemia	□Sickle Cell Disease
□Asthma	□Fainting Spells/Dizziness	□Irregular Heartbeat	□Sinus Trouble
□Blood Disease	□Frequent Cough	□Kidney Problems	□Spina Bifida
□Blood Transfusion	□Frequent Diarrhea	□Leukemia	□Stomach/Intestinal
□Breathing Problems	□Frequent Headaches	□Liver Disease	□Stroke
□Bruise Easily	□Genital Herpes	□Low Blood Pressure	□Swelling of Limbs
□Cancer	□Glaucoma	□Lung Disease	□Thyroid Disease
□Chemotherapy	□Hay Fever	□Mitral Valve Prolapse	□Tonsillitis
□Chest Pains	□Heart Attack/Failure	□Osteoporosis	□Tuberculosis
□Cold Sores/Fever Blisters	□Heart Murmur	□Pain in Jaw Joints	□Tumors or Growths
□Congenital Heart Disorder	□Heart Pacemaker	□Parathyroid Disease	□Ulcers
□Yellow Jaundice	□Heart Trouble/Disease	□Psychiatric Care	□Venereal Disease

Have you ever had any serious illness not listed? □Yes □No If yes_____
Comments:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.
Signature of Patient, Parent or Guardian:_____ Date:_____