WELCOME

We are looking forward to having you join our great family of friends and patients. The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve.

ABOUT YOU

Today's Date: ____________________ Email address: ________________________________

(We will be emailing you our monthly newsletter, special promotions and holiday hours. We do not sell our email list.)

Last Name: _______________ First Name: _________________ MI: ____ ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. Preferred: ____________

Birthdate: ___________ Social Security # ____-____-____ Age: ____ ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home Address: ______________________________________ City: _______________ State: ________ Zip Code: _________

Home Phone: ________________ Cell: __________________ Work Phone: ________________ Driver's License #: _______________

Where / When are the best times to reach you? ________________________ Whom may we thank for referring you? _______________

Other family members seen by us? ____

Employer: ____ How long there? ___________ Occupation: ___________________

Address: ____ City: _______________ State: _______________ Zip Code: _________

IN CASE OF EMERGENCY

Contact Name: _____________________ Relation: _________________ Home Phone: _____________ Cell Phone: _____________

Address: ____ City: _______________ State: _______________ Zip Code: _________

RESPONSIBLE PARTY INFORMATION

Person Responsible for Account: ________________________________ Relation to Patient: __________________________________

Home Phone: _________________________ Cell: ___________________________ Work Phone: _______________________________

Mailing Address: ___________________________________ City: _______________ State: _______________ Zip Code: _________

Social Security #: ____-____-____ Driver's License #: ______________________

Employer: ____ Occupation: ___________________________

Employer's Address: ________________________________ City: _______________ State: _______________ Zip Code: _________

INSURANCE INFORMATION

Insured's Name: _______________________ Social Security #: _________________ DOB: __________________

Employer: ____

Insurance Company/Plan: ______________ Union/Group Name: _____________ Group/Policy #: __________ Local Ph #: _________

Do you have dual coverage? ☐ Yes ☐ No *(If yes, please provide the following secondary information)*

Insured's Name: _______________________ Social Security #: _________________ DOB: __________________

Employer: ____

Insurance Company/Plan: ______________ Union/Group Name: _____________ Group/Policy #: __________ Local Ph #: _________

MEDICAL HISTORY

Wanlan Xiao, DDS
Family, Cosmetic and Sedation Dentistry

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: ______________________________

Physician's Address: ______________________________

____

Phone #: ____________________ Last Visit: __________

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a Physician? ☐ Yes ☐ No

Please explain: ______________________________

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

For WOMEN: Are you taking birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Unsure ☐ Yes ☐ No

Week #: __________ Are you nursing? ☐ Yes ☐ No

Do you have or have you experienced any of the following?

☐ Y ☐ N Abnormal Bleeding	☐ Y ☐ N Difficulty Breathing	☐ Y ☐ N High Blood Pressure	☐ Y ☐ N Scarlet Fever
☐ Y ☐ N Alcohol Abuse	☐ Y ☐ N Drug Abuse	☐ Y ☐ N HIV / AIDS	☐ Y ☐ N Seizures
☐ Y ☐ N Allergies or Hives	☐ Y ☐ N Emphysema	☐ Y ☐ N Hyper / Hypoglycemia	☐ Y ☐ N Shingles
☐ Y ☐ N Anemia	☐ Y ☐ N Epilepsy	☐ Y ☐ N Kidney Problems	☐ Y ☐ N Sickle Cell Disease
☐ Y ☐ N Angina Pectoris	☐ Y ☐ N Ever Hospitalized	☐ Y ☐ N Liver Disease	☐ Y ☐ N Sinus Problems
☐ Y ☐ N Arthritis	☐ Y ☐ N Fainting Spells	☐ Y ☐ N Low Blood Pressure	☐ Y ☐ N Steroid Therapy
☐ Y ☐ N Artificial Bones/ Joints	☐ Y ☐ N Glaucoma	☐ Y ☐ N Lupus	☐ Y ☐ N Stroke
☐ Y ☐ N Artificial Heart Valves	☐ Y ☐ N Hay Fever	☐ Y ☐ N Mitral Valve Prolapse	☐ Y ☐ N Thyroid Problems
☐ Y ☐ N Asthma	☐ Y ☐ N Headaches	☐ Y ☐ N Nervousness	☐ Y ☐ N Tonsillitis
☐ Y ☐ N Cancer	☐ Y ☐ N Heart Attack	☐ Y ☐ N Pacemaker	☐ Y ☐ N Tuberculosis (TB)
☐ Y ☐ N Chemotherapy	☐ Y ☐ N Heart Murmur	☐ Y ☐ N Persistent Cough	☐ Y ☐ N Ulcers
☐ Y ☐ N Chicken Pox	☐ Y ☐ N Heart Surgery	☐ Y ☐ N Psychiatric Problems	☐ Y ☐ N Venereal Disease
☐ Y ☐ N Colitis	☐ Y ☐ N Hemophilia	☐ Y ☐ N Radiation Treatment	
☐ Y ☐ N Congenital Heart Defect	☐ Y ☐ N Hepatitis	☐ Y ☐ N Recent Weight Loss	
☐ Y ☐ N Diabetes	☐ Y ☐ N Herpes / Fever Blisters	☐ Y ☐ N Rheumatic Fever	

Please list any serious medical condition(s) you have experienced: ______________________________

____

Please list current medications: (prescription and over-the-counter including herbal supplements): ______________________________

____

Please list previous surgeries: ______________________________

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING

☐ Y ☐ N Aspirin	☐ Y ☐ N Dental Anesthetics	☐ Y ☐ N Jewelry / Metals	☐ Y ☐ N Sedative
☐ Y ☐ N Codeine	☐ Y ☐ N Erythromycin	☐ Y ☐ N Latex	☐ Y ☐ N Sulfa Drugs
☐ Y ☐ N Other __________________		☐ Y ☐ N Penicillin	☐ Y ☐ N Tetracycline

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DENTAL and ORAL HEALTH HISTORY

Why have you come to the dentist today? ____________

____

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before treatment? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Previous dentist: ____________

Date of last X-rays: ________ Date of last cleaning: ________

Are you happy with the way your smile looks? ☐ Yes ☐ No

If not, what would you change? ____________

____

If you have had any of the following dental care, please list the dentists and approximate dates:

Periodontal (gum) treatment or surgery: ____________

"Braces" or any type of orthodontic treatment: ____________

Dental implants: ____________

Any type of oral surgery: ____________

Do you have / have you had / have you noticed any of the following signs or symptoms in your head, neck or mouth:

Teeth that are sensitive to hot, cold, sweets, or biting pressure	☐ Yes	☐ No
Unpleasant taste or persistent bad breath	☐ Yes	☐ No
Does food catch between your teeth	☐ Yes	☐ No
Do your gums bleed when brushing	☐ Yes	☐ No
Red, swollen, tender, bleeding, or sore gums	☐ Yes	☐ No
Gums that have pulled away from the teeth	☐ Yes	☐ No
Pus between the teeth and gums	☐ Yes	☐ No
Avoid any area when brushing or chewing	☐ Yes	☐ No
You clench or grind your teeth	☐ Yes	☐ No
A clicking, snapping or difficulty when chewing	☐ Yes	☐ No
Difficulty opening or moving the jaws	☐ Yes	☐ No
Difficulty speaking or changes in your voice	☐ Yes	☐ No
Loose or separating teeth	☐ Yes	☐ No
Changes in the way your teeth fit together	☐ Yes	☐ No
Color change of the tissues inside your mouth	☐ Yes	☐ No
Pain, tenderness, numbness, or earaches	☐ Yes	☐ No
Any lumps, swelling or swollen glands	☐ Yes	☐ No
Sores, ulcers, or rough spots in your mouth	☐ Yes	☐ No

How many times a day do you brush your teeth? ________ How many times a week do you floss your teeth? ________

Do you use any of the following:

Mechanical (electric) toothbrush?	☐ Yes	☐ No	If Yes, what type or brand? ________
Flossing aids (floss holders, threaders, etc.)	☐ Yes	☐ No	
Oral irrigating device (Waterpik)	☐ Yes	☐ No	
Fluoride treatments or supplements at home	☐ Yes	☐ No	If Yes, what type or brand? ________
Mouthwashes or oral rinses	☐ Yes	☐ No	If Yes, what type or brand? ________

Do you have any missing teeth that have not been replaced? ☐ Yes ☐ No If Yes, why have you not had them replaced?

____

Do you wear any removable dental appliances? ☐ Yes ☐ No If Yes, what type and for how long?

____

Are you concerned about the finances required to return your mouth to excellent health? ☐Yes ☐No

Are you frustrated because you always need something treated or repaired when you visit a dentist? ☐Yes ☐No

Do you feel you will eventually wear artificial dentures? ☐Yes ☐No

Have you ever had any complications from an extraction or dental treatment? ☐Yes ☐No

If Yes, please explain: ____________

Have you ever had any other dental conditions, major trauma or injury to your head, neck or mouth? ☐Yes ☐No

If Yes, please specify: ____________

ORAL CANCER EVALUATION

Patient's Name: ______________________________

1. Do you smoke or have you EVER smoked? ☐ Yes ☐ No
(If No, proceed to question 2)

The amount that you are presently smoking - *(check ALL that apply)*

☐ None (quit smoking completely) ☐ An occasional cigar ☐ Occasional pipe smoker
☐ An occasional cigarette ☐ 1-2 packs of cigarettes per day ☐ A pipe on a daily / regular basis
☐ A few cigarettes per day ☐ 2 or more packs of cigarettes per day
☐ Less than 1 pack of cigarettes per day ☐ Cigars on a daily / regular basis

If you have quit smoking, when did you quit? ☐ Fewer than 6 months ago ☐ 6 months ago ☐ 1-3 years ago ☐ More than 3 years ago
How many years have you or did you smoke? ☐ Fewer than 2 years ☐ 2-5 years ☐ 5-10 years ☐ More than 20 years

2. Do you chew / have you EVER chewed tobacco or used snuff or other similar substances? ☐ Yes ☐ No
(If No, proceed to question 3)

Are you still using smokeless tobacco or snuff? ☐ Yes ☐ No
If No, when did you quit? ☐ Fewer than 6 months ago ☐ 6 months ago ☐ 1-3 years ago ☐ More than 3 years ago
How many years did you use or have you used smokeless tobacco? ☐ Fewer than 2 years ☐ 2-5 years ☐ 5-10 years ☐ More than 20 years

3. Approximate average amount of alcoholic beverages presently consumed per week:
☐ None ☐ Fewer than 1 per week ☐ 1-5 drinks ☐ 6-11 drinks ☐ 11-20 drinks ☐ More than 20 drinks

4. Do you have or have you ever had a substance abuse problem? ☐ Yes ☐ No
Describe:

5. Do you presently use any recreational drugs? ☐ Yes ☐ No
List:

6. Do you have or have you ever had an eating disorder? ☐ Yes ☐ No
If Yes, please specify:

7. Do you have or have you ever had any head, neck or mouth piercings *(other than ears)* ☐ Yes ☐ No
List:

8. Do you have or have you ever been informed that you have been infected with an oncogenic strain (possible cancer-causing) of the Human Papilloma Virus (HPV)? ☐ Yes ☐ No

9. Please list your history or any family member's history of cancer: ______________________________

____

10. Other concerns or considerations: ______________________________

____

CONSENT - To the best of my knowledge, all of the preceding information is correct and if there is ever any change in health, or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further notice I understand there are no guarantees or warranties in health or dental care.

Signature: ______________________________ Date: ______________

CONSENT FOR SERVICES AND OFFICE POLICIES

Financial and Insurance Policies:
It is our objective to provide our patients with cutting edge dental technology, superior dental materials and expert care in a modern comfortable environment.

In order to provide this quality of dental care, we request all of our patients pay their estimated personal cost of treatment at the time of their visit. As a courtesy to our patients, we will file your dental insurance claims and bill your dental insurance company for treatments you receive. However, in the event the insurance company, for any reason, does not pay the estimated portion of the bill, the balance will become the patient's responsibility and will be billed directly to you.

Please take the time to read and understand your insurance policy and benefits. In most cases, dental insurance is a contract between your employer and a dental insurance company. The benefits you receive are based on the terms of the contract that was negotiated between your employer and the dental insurance company, and not our dental office. Our goal is to help you achieve and maintain optimal dental care. Our office will do everything possible to help you understand and make the most of your dental insurance benefits.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

A service charge of 1.5% (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangement are satisfied. Any accounts past due over 90 days will be forwarded to a collection agency.

The fee estimate listed for dental care can only be extended for a period of 30 days from the date of patient examination.

Policies for X-rays and Dental Records:
X-rays in conjunction with a clinical exam are necessary in order to devise a complete and accurate diagnoses and dental treatment plan. Examination x-rays are generally taken once a year for adults and children. However, the frequency at which x-rays are taken will be determined based upon each patient's individual dental needs. Please be advised that if you wish to have your x-rays transferred to another office, a release form must be signed.

Office Cancellation Policy:
We pride ourselves in providing extra time for the personal attention each patient deserves. Your appointment time in this office will be reserved exclusively for you. We respect your time and make every effort to keep you from waiting. We request you provide us with **at least 48 hours notice if you need to reschedule your appointment.** We reserve the right to charge a cancellation fee to patients who fail to cancel or reschedule without adequate notice.

Proposition 65:
The state of California, under Proposition 65, now requires every dentist to give each of their patients a copy of the information relating to materials and techniques used in the dental environment. This information is contained in the attached document entitled "DENTAL MATERIALS FACT SHEET." It is required that all patients sign they have received a copy of this document. We would appreciate you taking the time to sign the bottom of this form certifying you have received a copy of the DENTAL MATERIALS FACT SHEET. If you have any questions regarding information contained within the document, please let us know.

Notice of Privacy Practices:
This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review the brochure titled Notice of Privacy Practices and kindly sign the bottom of this form indicating that you have received notice of this office's Notice of Privacy Practices.

I have read the above conditions of treatment and payment and agree to their content.

______________________________________ ____________________

Signature of patient, parent or guardian Date

______________________________________ ____________________

Signature of Guarantor of payment / responsible party Date

Signature of receipt of DENTAL MATERIALS FACT SHEET: ______________________________

Signature of receipt of NOTICE OF PRIVACY PRACTICES: ______________________________

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AUTHORIZATION

1. I understand that the information is correct and to the best of my knowledge. I understand it will be held in the strictest of confidence and only to be used to improve communication between the doctor and myself. It is my responsibility to inform the dental office of any changes in Medical History.

2. The undersigned herby authorizes the doctor to order x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.

3. I also authorize the doctor to perform all recommended treatment(s) mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient): ____________________________________ . I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.

Signature: ____ Date: ____________________