live & smile
DENTAL & ORTHODONTICS
Dr. Zoe Huang & Associates

Patient Information

Date: _____

Patient Name: _____ ◯ Male ◯ Female DOB: _____ Age: _____
Last First M.I. *(MM/DD/YY)*

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Social Security #: _____

Marital Status: ◯ Minor ◯ Single ◯ Married ◯ Divorced ◯ Separated

Name of Employer/School: _____ Occupation: _____

How did you hear about our office? _____

In case of emergency, who can we contact? _____ Relationship: _____ Phone: _____

Name of physician: _____ Phone: _____

Health History

List all medications you are presently taking: _____

_____

Were you treated or are you presently scheduled to begin treatment with intravenous bisphosphonates ◯ Yes ◯ No

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV	☐ Cortisone Treatments	☐ Jaw Pain	☐ Skin Rash
☐ Anemia	☐ Cough, persistent or bloody	☐ Kidney Disease	☐ Special Diet
☐ Arthritis, Rheumatism	☐ Diabetes	☐ Liver Disease	☐ Stroke
☐ Artificial Heart Joints	☐ Emphysema	☐ Low Blood Pressure	☐ Swollen Feet or Ankles
☐ Artificial Joints	☐ Epilepsy	☐ Mitral Valve Prolapse	☐ Swollen Neck Glands
☐ Asthma	☐ Fainting or dizziness	☐ Nervous Problems	☐ Thyroid Problems
☐ Back Problems	☐ Glaucoma	☐ Pacemaker	☐ Tonsillitis
☐ Bleeding abnormally	☐ Headaches	☐ Psychiatric Care	☐ Tuberculosis
☐ Blood Disease	☐ Heart Murmur	☐ Radiation Treatment	☐ Tumor/growth on head/neck
☐ Cancer: _____	☐ Heart Problems	☐ Respiratory Disease	☐ Ulcer
☐ Chemical Dependency	☐ Hepatitis Type: _____	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Herpes	☐ Scarlet Fever	☐ Weight gain/loss, unexplained
☐ Circulatory Problems	☐ High Blood Pressure	☐ Shortness of Breath	☐ Other(s): _____
☐ Congenital Heart Lesions	☐ Jaundice	☐ Sinus Trouble	

Do you have any allergies?

☐ Aspirin	☐ Penicillin	☐ Local Anesthetic	☐ Other: _____
☐ Codeine	☐ Latex	☐ Sulfa	

For our female patients, is there any chance that you are pregnant? ◯ Yes ◯ No Are you using birth control? ◯ Yes ◯ No

Please list any health conditions/medications you have/take that may depress your immune system: _____

Are you presently under a physician's care? ◯ Yes ◯ No If yes, please indicate why: _____

Do you smoke or use any form of tobacco or electronic cigarettes? ◯ Yes ◯ No How often? _____

Do you drink or use any chemical substances? ◯ Yes ◯ No How often? _____

How often do you consume sugary products (e.g., candy, soda, juices)? ◯ Daily ◯ Weekly ◯ Rarely

Dental Health

When was the approximate date of your last dental visit? _____ Your last dental X-Rays? _____

(Note: If you have dental X-Rays within the last 12 months, please forward them to us at doctor@liveandsmiledental.com)

What is the main reason for your visit? _____

When would you like to start treatment? _____

How often do you brush? _____ time(s) per ◯Day ◯Week How often do you floss? ____ time(s) per ◯Day ◯Week

Do you ever feel (or have you ever been told) that you have bad breath? ◯Yes ◯No

Do your gums feel tender or swollen or sometimes bleed? ◯Yes ◯No

Do you avoid brushing any part of your mouth because of pain? ◯Yes ◯No If so, which parts? _____

Which types of foods cause you twinges of pain? ◯Hot ◯Cold ◯Sour ◯None

Do you chew on only one side of your mouth? ◯Yes ◯No If so, explain: _____

Do you clench or grind your jaws while sleeping or during the day? ◯Yes ◯No

Do your jaws ever feel tired? ◯Yes ◯No

Do you ever get sores/blisters on your lips/in your mouth? ◯Yes ◯No

Do you use a removable oral appliance (e.g., retainer, sports guard, CPAP, denture, etc.)? ◯Yes ◯No What type: _____

_____ _____

Patient/Guardian Signature *Date*

_____ _____

Doctor Signature *Date*