JENSEN C. SUN, D. D. S.
1300 MERIDIAN AVENUE
SAN JOSE, CALIFORNIA 95125
TELEPHONE (408) 264- 9203

We are pleased you have selected us to provide dental care for you and your family.
Whom may we thank for referring you to our office? ______________________

## PATIENT INFORMATION

Date __________ Patient's Name ______________________ (Last / First / Middle)

Address ______________________ (Street / City / State / Zip) How long lived there? __________

Home Ph. # (   ) __________ Work # (   ) __________ Cell # (   ) __________

Soc. Sec. # __________ Drivers Lic. # __________ E-mail: __________

Birthdate __________ Sex ☐ M ☐ F If patient is a minor, give parent's/guardian's name __________

In case of an emergency, name and address of two persons not living with you:

1) ______________________ Ph. # (   ) __________

2) ______________________ Ph. # (   ) __________

If patient is a full-time student, fill in school name __________

I will be paying today by: ☐ Cash ☐ Check ☐ Credit Card __________

## RESPONSIBLE PARTY INFORMATION

Name ______________________ (Last / First / Middle) Marital Status __________

Soc. Sec. # __________ Birthdate __________ Relationship to Patient __________

Address ______________________ (Street / Unit # / City / State / Zip)

How long? __________ Home Ph.# (   ) __________ Work Ph. # (   ) __________ E-mail: __________

Employer __________ Occupation __________ No. Years Employed __________

Employer Address __________

Spouse's Name __________

Soc. Sec. # __________ Birthdate __________ Work Ph. # __________

Employer __________ Occupation __________ No. Years Employed __________

Employer Address __________

## INSURANCE INFORMATION

Insured's Name __________ Soc. Sec. # __________ Insured's DOB __________

Insurance Company __________ Group # __________

Insurance Co. Address __________ Ph. # (   ) __________

Is your policy connected with your union? ☐ Yes ☐ No Name of Union __________ Local # __________

Do you have dual coverage? ☐ Yes ☐ No **If Yes: Please complete the following secondary Insurance information.**

Insured's Name __________ Insured's Soc. Sec. # __________

Insurance Company __________ Group # __________ Local # __________

Insurance Co. Address __________ Ph. # (   ) __________

Insured's Employer __________ Ph. # (   ) __________

## DENTAL INFORMATION

Reason for today's visit? __________

Date of last dental visit? __________ Cleaning? __________ X-rays? __________ What was done at the last time? __________

Former Dentist Name __________ City __________

How long do you expect to keep your natural teeth? __________

Are you pleased with the appearance of your smile? __________

Have you experienced lately: (circle items that apply)

| | | | | |
|---|---|---|---|---|
| Pain discomfort | Clenching of teeth | Bleeding/swollen gums | Food traps | Unpleasant odors or taste |
| Trouble flossing | Discolored teeth | Broken teeth or fillings | Sensitivity: hot/cold/sweets | |

Have you had any unfavorable reaction to medical or dental care? ☐ Yes ☐ No

Do you have any fear of dental work? ☐ Yes ☐ No

Do you have any pain, clicking or discomfort around ears, jawline, face or neck? ☐ Yes ☐ No

Can you chew food comfortably? ☐ Yes ☐ No

How would you describe your attitude toward dental treatment? ☐ Relaxed ☐ Uneasy ☐ Tense ☐ Very apprehensive

OVER ➔

## MEDICAL INFORMATION

1. Have you been a patient in the hospital during the last two years? ...................... Yes No
2. Are you now taking any medications or drugs? .................................................. Yes No
   If yes, please list: ______________________________
3. Do you need to premedicate for dental treatment? .............................................. Yes No
4. Have you ever taken appetite suppressants- fen-phen(fenluramine &Phentermine) or dexfenfluramine or fenfluramine? ............. Yes No
5. Physician's name and address: ______________________________ Ph. # ( ) ______________
6. Are you sensitive or allergic to any medication or anesthetics? ........................... Yes No
7. **Is there any issues or conditions that you would like to discuss with the dentist in private? ............................................. Yes No**
8. Indicate which of which of the following you have had or have at the present . Circle "Yes or No" to each item.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart failure | Yes | No | Artificial Joints(hip,knee,etc.) | Yes | No | Hepatitis | Yes | No |
| Heart disease or Attack | Yes | No | Kidney trouble | Yes | No | If yes, which strain? (circle) | A B C | |
| Angina Pectoris | Yes | No | Ulcers | Yes | No | Venereal Disease | Yes | No |
| Congenital Heart Disease | Yes | No | Diabetes | Yes | No | A.I.D.S | Yes | No |
| Heart Mumur | Yes | No | Thyroid Problems | Yes | No | H.I.V. Positive | Yes | No |
| High Blood Pressure | Yes | No | Glaucoma | Yes | No | Cold Sores/Fever Blisters | Yes | No |
| Arteriosclerosis | Yes | No | Cancer | Yes | No | Blood Transfusion | Yes | No |
| Mitral Valve Prolapse | Yes | No | Emphysema | Yes | No | Hemophilia | Yes | No |
| Arificial Heart Valve | Yes | No | Chronic Cough | Yes | No | Anemia | Yes | No |
| Heart Pacemaker | Yes | No | Tuberculosis | Yes | No | Sickle Cell Disease | Yes | No |
| Heart Surgery | Yes | No | Asthma | Yes | No | Bruise Easily | Yes | No |
| Rheumatic Fever | Yes | No | Migraine | Yes | No | Liver Disease | Yes | No |
| Cortisone Medicine | Yes | No | Allergy or Hives | Yes | No | Yellow Jaundice | Yes | No |
| Drug Addiction | Yes | No | Sinus Trouble | Yes | No | Epilepsy Seizures | Yes | No |
| Stroke | Yes | No | Radiation Therapy | Yes | No | Fainting or Dizzy Spells | Yes | No |
| Allergy to Latex | Yes | No | Chemotherapy | Yes | No | Hay Fever | Yes | No |
| Allergy to Metal (jewelry,etc.) | Yes | No | Developmentally Disabled | Yes | No | Nervousness | Yes | No |
| Bisphosphorates (Fosomax) | Yes | No | Osteoporosis | Yes | No | Tumors | Yes | No |

**DOCTOR'S NOTES:** ______________________________

______________________________

**FOR WOMEN ONLY:** Are you taking birth control pills? Yes No
Are you pregnant? Yes No What Month? __________ Are you nursing? Yes No

**I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. Futhermore, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the competion of this form.**

Patient Signature ______________________________ Date __________

**Consent:**

1. **The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.**
2. **I also authorize doctor to perform all recommended treatment 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 anesthetics agents embodies a certain risk. Futhermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.**
3. **I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account, in addition to any collections charges.**
4. **I understand that where appropriate, credit bureau reports may be obtained.**
5. **I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.**
6. **I authorize the use of my social security number to file my dental claim.**
7. **I have been informed that cancellations without 48 working hours notice may incur a charge of $75/hour.**

Patient Signature ______________________________ Date __________ Witness ______________
Parent or Responsible Party ______________________________ Relationship to Patient ______________

## MEDICAL UPDATES

**I have reviewed my Health History and confirm that it accurately states past and present conditions.**

| **Date** | **Patient Signature** | **Changes to Health History** | **Dentist Initials** |
|---|---|---|---|
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