DATE

Welcome to Chew Chew Dental

17130 Magnolia St. • Fountain Valley, CA 92708 | 714.842.5539
info@chewchewdental.com

Patient Info

First Name: _____ MI: _____ Last Name: _____ Preferred Name: _____

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ M ◯ F Birth Date: _____ Age: _____ Family Status: ◯ Single ◯ Married ◯ Minor ◯ Other

Social Security #: _____ Drivers License #: _____ Email Address: _____

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

Phone: Home _____ Mobile _____ Work _____ Best time to call: _____

How would you like to be contacted (select more than one): ☐ PHONE ☐ E-MAIL ☐ TEXT message

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____ Phone Number: _____

How did you hear about our office? _____

Dental History

Date of last dental visit _____ Name of previous dentist _____

Why are you changing dentists? _____

Reason for today's visit: (check all that apply) ☐ Check-up ☐ Cleaning ☐ Pain ☐ Other(use space below)

Place a mark on "Yes" or "No" to indicate if you have had any of the following

Clicking or popping jaw	☐ Yes ☐ No	Dry mouth	☐ Yes ☐ No	Bad Breath	☐ Yes ☐ No
Grinding Teeth	☐ Yes ☐ No	Food collection between the teeth	☐ Yes ☐ No	Bleeding gums	☐ Yes ☐ No
Jaw pain or tiredness	☐ Yes ☐ No	Loose teeth or broken fillings	☐ Yes ☐ No	Gums swollen or tender	☐ Yes ☐ No
Orthodontic treatment	☐ Yes ☐ No	Sensitivity to Hot/Cold	☐ Yes ☐ No	Periodontal treatment	☐ Yes ☐ No
Pain around ear	☐ Yes ☐ No	Sensitivity to Biting/Chewing	☐ Yes ☐ No	How often do you floss?	_____
Chew on side of mouth	☐ Yes ☐ No	Sensitivity to Sweets	☐ Yes ☐ No	How often do you brush	_____

1. Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

2. Have you ever had any unfavorable reaction to dental anesthetic? ☐ Yes ☐ No, If yes, please explain _____

3. Does dental treatment make you nervous? ☐ No ☐ Yes, Slightly ☐ Yes, Moderately ☐ Yes, Extremely

4. Do you like your smile? ☐ Yes ☐ No If you could change your smile, what would you like to change? _____

5. I am interested in (check all that apply): ☐ Teeth Whitening ☐ Replacement of Missing Teeth ☐ Cosmetic Evaluation ☐ Straight Teeth ☐ Sedation ☐ White (Natural) Fillings ☐ Home Care ☐ Breath Control

Medical History

1. Are you ALLERGIC or have adversely reacted to any of the following:

☐ Aspirin ☐ Dental Anesthetics ☐ Latex ☐ Milk ☐ Tetracycline ☐ Other
☐ Codeine ☐ Iodine ☐ Metals ☐ Sulfa Drugs ☐ Valium or Other Sedative If other, please describe _____

2. Have you ever had any of the following Please answer **YES** question by marking the boxes below.

☐ Anemia	☐ Blood Disease	☐ Drug Addiction	☐ Heart Attack	☐ Low Blood Pressure	☐ Shortness of Breath
☐ Angina Pectoris	☐ Blood Transfusion	☐ Epilepsy/Seizures	☐ Heart Murmur	☐ Mental Disorders	☐ Sinus Problems
☐ Anxiety	☐ Bruise Easily	☐ Excessive Bleeding	☐ Hemophilia	☐ Mitral Valve Prolapse	☐ Skin Rash
☐ Arthritis	☐ Cancer	☐ Frequent Headaches	☐ Hepatitis Type:	☐ Nervous Disorders	☐ Stroke
☐ Artificial Heart Valves	☐ Chemotherapy	☐ GERD/Acid Reflux	☐ High Blood Pressure	☐ Pacemaker	☐ Swelling Feet/Ankles
☐ Artificial Joints	☐ Cold Sores	☐ Glaucoma	☐ HIV/AIDS	☐ Radiation Treatment	☐ Thyroid Disease
☐ Heart Disease	☐ Depression	☐ Growths/Tumors	☐ Jaundice	☐ Respiratory Disease	☐ Tuberculosis
☐ Asthma	☐ Diabetes	☐ Hay Fever	☐ Kidney Disease	☐ Rheumatic Fever	☐ Ulcers
☐ Back Problems	☐ Dizziness/Fainting	☐ Head Injuries	☐ Liver Disease	☐ Rheumatism	☐ Venereal Disease/STD

3. Do you have any other health problems or conditions not listed above?
◯ Yes ◯ No

If yes, please specify: _____

4. Are you under the care of a Physician? ◯ Yes ◯ No

If yes, please specify and provide Doctor Name and Contact Info

_____

5. Have you been admitted to a hospital or needed emergency care during the past 2 years? ◯ Yes ◯ No

If yes, please specify: _____

6. Are you taking any medications at the is time? ◯ Yes ◯ No

If yes, please specify and/or provide List of Medication
(use back side of page 3 if needed)

_____

7. Have you ever taken or are currently taking any BISPHONATES orally or through IV (ie Fosamx, Bonica, Actonel)? ◯ Yes ◯ No

If yes, please specify and provided List of Medication _____

8. Do you SMOKE? ◯ Yes ◯ No ☐ Cigarette ☐ Pipe ☐ Cigars ☐ Electronic/Vaping If yes how many cigarettes do you smoke per day _____

9. WOMEN: are you currently PREGNANT? ◯ Yes ◯ No **9A.** NURSING? ◯ Yes ◯ No 9B. Currently taking any birth control? ◯ Yes ◯ No

10. Do you use recreational drugs? ◯ Yes ◯ No If yes, for how many MONTHS? _____

If yes, please specify and provided List of drugs _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian: _____ Date: _____

Reviewed By: _____ Date: _____

Recall Medical History Review

If there is no changes to the above information you provided, please sign and date below:

1. Date: _____ Updates: _____ Initial: _____ Review By: _____
2. Date: _____ Updates: _____ Initial: _____ Review By: _____
3. Date: _____ Updates: _____ Initial: _____ Review By: _____
4. Date: _____ Updates: _____ Initial: _____ Review By: _____
5. Date: _____ Updates: _____ Initial: _____ Review By: _____

Insurance Info

PRIMARY

Name of insured: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Insured's Birth Date: _____ ID/Group #: _____ Insured Social Security #: _____

Name of Employer: _____ Address of Employer: _____ State: _____ Zip: _____

Insured's Company: _____ Policy Number: _____

SECONDARY/MEDICAL

Name of insured: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Insured's Birth Date: _____ ID/Group #: _____ Insured Social Security #: _____

Name of Employer: _____ Address of Employer: _____ State: _____ Zip: _____

Insured's Company: _____ Policy Number: _____

Financial Policy

I, the undersigned certify that I (or my dependent) have insurance coverage with the Insurance company I listed above and assign directly to Dr. James C Chiu all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financial responsible for all charges whether or not paid by insurance. I will inform Chew Chew Dental if there are any changes to my insurance information. I hereby authorize Chew Chew Dental to release all information necessary to secure the payment of benefits. I authorize the user of this signature of all insurance submissions

Signature of financial party _____ Date _____

Authorization and Release

By Signing Below you are acknowledging that:

1) To the best knowledge, all the preceding answers and information provided are true and correct. If you ever have any changes, you will inform the office as soon as possible
2) You hereby grant authority to the dental provider(s) in charge of the care of the patient whose name appears on this form, to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient, i.e. x-ray and exam; and to administer such anesthetic, sedative, and nitrous oxide sedation as advisable in the treatment of this patient.
3) You further allow Chew Chew Dental to release your dental record and/or xray to necessary outside care specialist for consult and/or treatment if needed.
4) You grant permission to Chew Chew Dental to telephone you at home or at work to discuss matter related to your oral health.
5) You have read the above conditions of treatment and payment and agree to their content .

_____ _____ _____

Signature of patient, parent or guardian | Date | Relationship to Patient

CANCELLATION POLICY

I understand that if I must cancel any appointment, I will provide the office at least a 24-hour notice. I understand that last minute cancellation/missed appointment may incur up to $50/hour of appointment-time cancellation/missed fee. Initial _____

HIPPA ACKNOWLEDGMENT

I have read and been offered a copy of Chew Chew Dental's Notice of Privacy Practices

Patient Signature _____ Date _____

Dentist Signature _____ Date _____