## Po Po Chui D.M.D., LLC

# REGISTRATION

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| PATIENT INFORMATION

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| Patient’s last name:  |  | First: | Middle initial: | Date:  |  | Middle Initial |

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| Birth date: | Age: | Gender: |

Address:

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| Social Security no.: | Home phone no.: | Cell phone no.: |
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| Occupation: | Employer: | Employer phone no.: |
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| Email Address: |  |  |
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Married  Widowed  Single  Minor Spouse’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s birthday: \_\_\_\_\_\_\_\_\_\_Separated  Divorced  Partnered for \_\_\_\_\_ years Spouse’s SS # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_INSURANCE INFORMATIONInsurance Co. name / address:

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| Group #: | Subscriber #: | Insured name: | Relation: |
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| Insured Birthday: \_\_\_ / \_\_\_ / \_\_\_ | Insured SS #: | Insured employer: |  |
| Secondary Dental Insurance Co. name / address: |
| Group #: | Subscriber #: | Insured name: | Relation: |
| Insured birthday: \_\_\_ / \_\_\_ / \_\_\_ | Insured SS #: | Insured employer: |  |

Assignment and Release: I will review my treatment plan and release any info that affects my treatment. Signature of the patient, parent, guardian or personal representative:  All info is correct and confidential, and it is my responsibility to inform Dr. Chui \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ of changes, especially in my medical health. I authorize the office to be paid directly by my insurance, with any balance to be Printed name of patient, parent, guardian or personal representative: paid by myself within 90 days. After that, the balance will be sent to collections. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Payment is usually due in full at the time of service.  I acknowledge that I was offered a “Notice of Privacy Practices,” stating how the Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  office may use and disclose information pertaining to my health.Dental INFORMATION

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| Reason for visit:Former dentist:City/State:Date of last dental visit:Date of last dental X-rays:How often do you floss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How often do you brush? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ***Check the box: Yes No***Bad breath  Bleeding gums  Blisters on lips or mouth  Burning sensation on tongue  Chew on one side of mouth  Cigarette, pipe cigar smoking  Clicking or popping jaw  Dry mouth    | ***Check the box: Yes No***Fingernail biting  Food collects between teeth Foreign objects Grinding teeth Gums swollen or tender  Jaw pain or tiredness Lip or cheek biting Loose teeth or broken fillings  Mouth breathing  | ***Check the box: Yes No***Mouth pain, brushing Orthodontic treatment Pain around ear Periodontal treatment Sensitivity to cold Sensitivity to heat Sensitivity to sweets Sensitivity when biting Sores or growths in your mouth  |  |

Health History  Physician’s name: Date of last visit:

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|  | Have you ever taken any of the group of drugs collectively referred to as “len-phen?” These include combinations of lonimin, Apidex, Fastin (brand names of  phentermine), Pondimin (Fenfluramine) and Redux (Dextenfluramine). Yes No

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| ***Check the box:*** ***Yes No*** Heart Attack Stroke Cancer/Chemo Angina PectorisRheumatic FeverHIV/AIDSHeart Surgery Pace makerShingles | ***Yes No***  Mitral Valve ProlapseKidney Problems Artificial Bones Artificial Heart valves Sinus ProblemsHigh Blood PressureLow Blood PressureFever Blisters Frequent Headaches Psychiatric Problems | ***Yes No***  Epilepsy  SeizuresFainting Spells/ dizzinessDiabetesTuberculosis Alcohol AbuseDrug AbuseVenereal Disease HemophiliaAbnormal Bleeding | ***Yes No***  Ulcers ColitisSickle Cell DiseaseCongenital Heart lesionsAnemiaRadiation TherapyArthritis Hepatitis A Hepatitis B Asthma  | ***Yes No***  Difficulty Breathing Blood Transfusion Cosmetic Surgery EmphysemaGlaucoma Allergies |

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| ***Check the box:*****Yes No** Artificial joints  Back problems  Blood Disease  Circulatory problems  Cortisone treatments  Cough, persistent or bloody  GERD  Heart murmur  Heart problems  | **Yes No**Herpes  High cholesterol  Jaundice  Jaw pain  Liver disease  Nervous problems  Osteoporosis  Respiratory disease  Scarlet Fever  Shortness of breath  | **Yes No** Skin rash Special diet  Swollen feet or ankles  Swollen neck glands  Thyroid problems  Tonsillitis  Tumor growth on head or neck  Weight loss, unexplained Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Mouth pain, brushing Orthodontic treatment Pain around ear Periodontal treatment Sensitivity to cold Sensitivity to heat Sensitivity to sweets Sensitivity when biting Sores or growths in your mouth  | Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: | Work phone no.: |

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|  | Do you wear contact lenses? Yes No **Women:**Have you had a surgery? Yes No Are you pregnant? Yes No Due date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What was it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you nursing? Yes No  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date? \_\_\_\_\_\_\_\_\_\_\_ Taking birth control? Yes NoDo you smoke? Yes No What are you taking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MEDICATIONS Allergies

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| List any medications you are taking and the correlating diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pharmacy name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | AspirinMetalsCodeinePenicillinDental Anesthetics TetracyclineErythromycinSulfaJewelryIodine  |
| Emergency Contact Name and phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Latex Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Provider name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Provider signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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