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

# REGISTRATION

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| PATIENT INFORMATION  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | Patient’s last name: |  | First: | Middle initial: | Date: |  | Middle Initial |  |  |  |  | | --- | --- | --- | | Birth date: | Age: | Gender: |   Address:   |  |  |  | | --- | --- | --- | | Social Security no.: | Home phone no.: | Cell phone no.: | |  |  |  | | Occupation: | Employer: | Employer phone no.: | |  |  |  |  |  |  |  | | --- | --- | --- | | Email Address: |  |  | |  |  |  |   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:  |  |  |  |  |  | | --- | --- | --- | --- | --- | | Group #: | Subscriber #: | Insured name: | | Relation: | |  |  |  | |  | | 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  |  |  |  |  |  | | --- | --- | --- | --- | --- | | 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:   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  |  |  |  |  | |  | 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   |  |  |  |  |  | | --- | --- | --- | --- | --- | | ***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 | |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | ***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.: | | |  |  |
|  | 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 No  Do you smoke? Yes No What are you taking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MEDICATIONS Allergies  |  |  | | --- | --- | | 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |