DR. LAWRENCE WU
DR. KWANG KIM
DR. MIDORI TACHIBANA
DR. KAIN YI
DR. DANIEL McMILLAN
Oakland: 510 893-4041 Walnut Creek: 925 937-9017 Antioch: 925 777-1719

PATIENT INFORMATION FORM

Patient Name: _____

Birth Date: _____ **Social Security** #: _____

Home Address: _____

City: _____**State:** _____ **Zip:** _____

Home#( ) _____ **Cell#**( )_____

Work Phone :( ) _____

Employer: _____

Occupation: _____

Employer Address: _____

City: _____**State:** _____ **Zip:** _____

Whom should we contact in case of an Emergency: _____

Phone: ( ) _____

Relationship to Patient: _____

Whom May We *Thank* For Referring You To Our Friendly Dental Office?

☐ Professional Dental Brochure ☐ Lumineers ☐ Invisalign ☐ American Academy of Cosmetic Dentistry ☐ Zoom

☐ Top Cosmetic Dentists of America ☐ Best of the Bay ☐ Community Fair / Screening ☐ Website _____

☐ If referred by a Doctor, Friend or Family, *name:* _____

Primary Dental Insurance:

Name of Insurance Co: _____

Name of Subscriber: _____

Relation of Subscriber to Patient: _____

Subscriber Employer : _____

Social Security # of Subscriber: _____

Group #: _____

Birth Date of Subscriber: _____

Secondary Dental Insurance:

Name of Insurance Co: _____

Name of Subscriber: _____

Relation of Subscriber to Patient: _____

Subscriber Employer : _____

Social Security # of Subscriber: _____

Group #: _____

Birth Date of Subscriber: _____

We need the above information so that we can help obtain the dental insurance benefits you are eligible for. This may require submitting the Doctor's treatment plan to the insurance company(s) for a **pre-determination** of benefits, or in some cases obtaining the information by phone and internet. We can ***NEVER*** guarantee payment by your insurance company. The insurance company's contract is with you and your employer.

Policies and Procedure

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I certify the information on the Patient Information Form is true and correct to the best of my knowledge. I will notify Franklin Dental Care of any changes in my health status or any changes in the above information.

I authorize routine dental diagnostic procedures. If I accept the proposed treatment plan, I also agree to the use of local anesthetics and pre-medications considered necessary or advisable by the doctor for my comfort and well being.

Signature of Patient/Guardian: _____Date: _____

Dental History

Do you have a specific dental problem? _____ Yes No
Do you have dental examinations on a routine basis? Last visit?_____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do *you* like your smile? If not, discuss why not _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? _____ Yes No
Do you clench or grind your teeth? _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Do you smoke or chew? _____ Yes No
Any growths or sores in your mouth? If yes, explain _____ Yes No

Name of previous dentist _____ **Phone Number** _____

Date of last Full Mouth Xrays (18 small films or panoramic) _____

Medical History

Are you currently under a physician's care? If yes, why_____ Yes No
Have you ever been hospitalized or had a major operation? _____ Yes No
Have you ever had a serious injury to your head or neck? _____ Yes No
Are you on a special diet? _____ Yes No
Have you ever taken Fen-Phen? _____ Yes No

Are you Allergic to any of the following?: YES or NO (If yes, please mark or list which one)
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Other _____

Women Please check: ☐ Pregnant ☐ Trying to get pregnant ☐ Nursing ☐ Taking birth control

Please list all medications being taken at this time:

_____ _____ _____

_____ _____ _____

Please Check Yes or No **(NOTE: IT IS REQUIRED THAT YOU READ AND CHECK EITHER THE YES OR NO BOX INDIVIDUALLY! NO VERTICAL LINES THROUGH THE ROWS)**

Yes	No		Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Heart Trouble/Disease	☐	☐	Bruise Easily	☐	☐	Emphysema	☐	☐	Yellow Jaundice	☐	☐	Cold Sores
☐	☐	Heart Murmur	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐	Kidney Problems	☐	☐	Fever Blisters
☐	☐	Irregular Heart Beat	☐	☐	Excessive Bleeding	☐	☐	Cancer	☐	☐	Renal Dialysis	☐	☐	Herpes
☐	☐	Angina/ Chest Pain	☐	☐	Sickle Cell Disease	☐	☐	Radiation	☐	☐	Thyroid Disease	☐	☐	Stroke
☐	☐	Heart Attack/ Failure	☐	☐	Hemophilia	☐	☐	Chemotherapy	☐	☐	Parathyroid Disease	☐	☐	Convulsions
☐	☐	Congenital Heart Disorder	☐	☐	Leukemia	☐	☐	Stomach/Intestinal Disease	☐	☐	Arthritis/Gout	☐	☐	Epilepsy or Seizures
☐	☐	Mitral Valve Prolapse	☐	☐	Recent Blood Transfusion	☐	☐	Ulcers	☐	☐	Rheumatism	☐	☐	Fainting or Dizziness
☐	☐	Scarlet Fever	☐	☐	Swelling of Limbs	☐	☐	Recent Weight Loss	☐	☐	Pain in Jaw Joints	☐	☐	Glaucoma
☐	☐	Rheumatic Fever	☐	☐	Lung Disease	☐	☐	Frequent Diarrhea	☐	☐	Cortisone Medicine	☐	☐	Tumors or Growths
☐	☐	Artificial Heart Valve	☐	☐	Breathing Problems	☐	☐	Diabetes	☐	☐	Artificial Joint	☐	☐	Nervousness
☐	☐	Heart Pace Maker	☐	☐	Shortness of Breath	☐	☐	Excessive Thirst	☐	☐	Venereal Disease	☐	☐	Psychiatric Care
☐	☐	Heart Surgery	☐	☐	Frequent Cough	☐	☐	Hypoglycemia	☐	☐	AIDS	☐	☐	Alzheimer's Disease
☐	☐	HighBlood Pressure	☐	☐	Hay Fever	☐	☐	Liver Disease	☐	☐	HIV Positive	☐	☐	Allergies (Medicines)
☐	☐	Low Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Hepatitis A (Infectious)	☐	☐	Genital Herpes	☐	☐	Allergies (Pollen/Dust)
☐	☐	Blood Disease	☐	☐	Asthma	☐	☐	Hepatitis B or C	☐	☐	Drug Addiction/Alcoholism	☐	☐	Hives or Rash
☐	☐	Unexplained Fever	☐	☐	Bloody Sputum	☐	☐	Night Sweats	☐	☐	Tattoos	☐	☐	Need Premedication?

Have you ever had any other serious illness not checked above? Discuss _____ Yes or No

To the best of my knowledge, all preceding answers are correct. If I have any changes in my health status or if my medicines change, I will inform the dentist and staff at my next appointment without failure.

X_____ DATE_____ Reviewed by Doctor_____ DATE_____
PATIENT'S SIGNATURE (PARENT OR GUARDIAN) DOCTOR'S SIGNATURE

Medical Updates

I have read my MEDICAL HISTORY dated _____and I confirm that it adequately states past and present conditions

DATE	CHANGES		PATIENT'S SIGNATURE	REVIEWED BY DOCTOR
_____	_____	NO CHANGES	_____	_____
_____	_____	NO CHANGES	_____	_____
_____	_____	NO CHANGES	_____	_____
_____	_____	NO CHANGES	_____	_____