PATIENT INFORMATION

Welcome to Pearl Family Dentistry

PERSONAL

Patient First Name _____ M.I. _____ Last Name _____

Date of Birth (MM/DD/YYYY) _____ Gender: ☐M ☐F Married: ☐Y ☐N

Cell Phone (____)_____ Email _____

Employer _____ Work Phone (____)_____

If the patient is under 18, please also complete the following information:

Guarantor *First Name _____ M.I. _____ Last Name _____*

Date of Birth (MM/DD/YYYY) _____ Relationship to Patient _____

Cell Phone (____) _____ Work Phone (____)_____ Email _____

Preferred Contact Method ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Text ☐ Email

How did you hear about us? _____

(If someone referred you here, please write down their name so that we can thank them.)

ADDRESS AND HOME PHONE

Check this box if same address for the entire family: ☐ Home Phone (____)_____

Address _____

City _____ State _____ Zip _____

Dental Insurance

Patient relationship to subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name _____ Subscriber ID # _____

Insurance Company _____ Phone (____)_____

Employer _____ Group Name _____ Group # _____

Secondary Insurance [ ] Yes [ ] No

No Show Policy

Please understand that when we schedule your appointment, we are reserving time for your particular needs. We kindly ask that if you must change an appointment, please give us at least 24 hours' notice. This courtesy makes it possible to give your reserved time to another patient who would like it.

A "No Show/ Late Cancellation" is defined as missing an appointment without cancelling at least 24 hours before scheduled time. Patients who do not show up for appointment or cancel without 24-hour notice will be charged **$35** per appointment scheduled. The fee must be paid before you or your family member is seen in our office again. Three failed appointments may result in dismissal from the practice

If you are running more than ten minutes late, we may ask you to reschedule your appointment.

Signature _____ **Date** _____

ASSIGNMENT AND RELEASE

I, the undersigned, understand that I am financially responsible for all charges. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Patient/Guarantor Signature _**X**_____ Date _**X**_____

DENTAL HEALTH

Do you have ☐ Bleeding gum ☐ Sensitive to hot or cold ☐ Jaw problem ☐ Bad breath ☐ Teeth clenching/grinding
您有如下症状吗？ 牙龈出血 对冷、热敏感 颞下颌关节问题 口臭 磨牙

How often do you brush your teeth? _____ times a day （您一天刷几次牙？）

How often do you floss? _____ times a day （您一天用几次牙线？）

Have you ever had any orthodontic treatment? ☐ Yes ☐ No （您矫过牙吗？）

Reason for today's visit: _____ Are you in pain? ☐ Yes ☐ No
您今天看牙主述是： 您现在牙疼吗？

MEDICAL HISTORY

Name of Medical Doctor _____ City/State _____
家庭医生姓名 医生所在 城市

Emergency Contact _____ Phone (____)_____ Relationship _____
紧急情况联系人 联系人电话 与联系人关系

List all the medications or drugs you are now taking:
请列出您正在服用的药物：

☐ None （无）

_____

_____

_____

_____

Check medications or drugs you are allergic to:
您对何种药物过敏？

☐ None (无) ☐ Local Anesthetics (局部麻药)

☐ Aspirin (阿司匹林) ☐ Metals (金属)

☐ Codeine (可待因/麻醉止痛药) ☐ Penicillin (青霉素)

☐ Erythromycin (红霉素) ☐ Sulfa Drugs （磺胺类药）

☐ Latex Rubber（乳胶/橡胶） ☐ Other（其它）: _____

Check any medical conditions you may have: （若您有以下的相关状况，请在所在项处打勾或说明。）

☐ None 无
☐ AIDS/HIV 免疫缺陷性疾病
☐ Anemia 贫血
☐ Artificial Heart Valve 人工瓣膜
☐ Arthritis 关节炎
☐ Asthma/Hay Fever 哮喘
☐ Blood Clotting Problems 凝血性疾病
☐ Blood Transfusion 输血史
☐ Bronchitis 气管炎
☐ Cancer/Tumor or Growth 癌症/肿瘤
☐ Cardiac Pacemaker 心脏起搏器
☐ Chest Pain Upon Exertion 胸痛
☐ Damaged Heart Valve 心瓣膜疾病
☐ Diabetes 糖尿病
☐ Emphysema 肺气肿
☐ Epilepsy 癫痫
☐ Fainting Spells/Seizures 晕厥
☐ Fever Blisters/Herpes 疱疹
☐ Frequent Headaches 经常性头痛
☐ Frequently Dry Mouth/Sjogren 口干症
☐ Glaucoma 青光眼
☐ Heart Attack/Angina 心肌梗塞/心绞痛
☐ Heart Disease 心脏病
☐ Hepatitis/Jaundice 肝炎/黄疸
☐ High Blood Pressure 高血压
☐ Hives/Skin Rash 风疹
☐ Joint Replacement, Date: _____ 置换关节，请注明日期
☐ Kidney/Bladder Trouble 肾病
☐ Low Blood Pressure 低血压
☐ Osteoporosis 骨质疏松
☐ Psychiatric Problems 精神性疾病
☐ Radiation Therapy, Chemotherapy 放疗，化疗
☐ Rheumatic Fever 风湿热
☐ Sinus Trouble 鼻窦炎
☐ Stroke 中风
☐ Surgery 手术史
☐ Thyroid Problems 甲状腺疾病
☐ Tuberculosis 肺结核
☐ Pregnant (If Female) 怀孕（女性）

☐ Other（其它）: _____

By signing below, I certify that all of the above information is true to the best of my knowledge. I also understand that this information will be held in confidence and it is my responsibility to inform this office of any change in my medical status.

Patient/Guardian Signature (患者/家长 签名) **X**_____ Date (日期) **X**_____

Patient/Guardian Name (签名者姓名) _____