Centric Dental
A Bite of Better Living
Dr. Sherman Ng & Associates

Title: Mr. / Mrs./ Miss /Ms. / DR.

Last name: ________________________________

First name: ________________________________

DOB (mm/dd/yy): __________________________

Home Address: ____________________________

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Home #: _______________________ a.m ○ p.m. ○ Preferred

Work #: _______________________ a.m ○ p.m. ○ Preferred

Cell #: _________________________ a.m ○ p.m. ○ Preferred

E-mail: ____________________________________

In case of emergency, we should notify:

Name: ____________________________________

Phone #: __________________________________

Who should we thank for referring you to our office?

____

Primary Insurance: __________________________________

Name of Policy Holder: ______________________________

DOB of Policy Holder (mm/dd/yy): ______________________

Employer: ____

Policy / Group #: ____________________________________

Certificate / ID #: ___________________________________

Secondary Insurance: ________________________________

Name of Policy Holder: ______________________________

DOB of Policy Holder (mm/dd/yy): ______________________

Employer: ____

Policy / Group #: ____________________________________

Certificate / ID #: ___________________________________

I authorize release, to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same.

Signature ____

Dental History

1. When was your last dental visit? ______________________ Your last dental x-rays: ________________________
2. What is your chief concern today? ____
3. Are you satisfied with the appearance of your teeth? ____
4. How often do you see your dentist for regular cleaning? ____
5. How often do you brush your teeth?___________________ Use any other oral hygiene aids: ________________
6. Are you nervous about dental treatment? ____

Do you have or have ever had any of the following? Please check.

- ○ Need antibiotic prior to dental work
- ○ Trauma to facial region
- ○ Teeth sensitivity
- ○ Toothache
- ○ Bleeding gum
- ○ Dental implant
- ○ Grinding / Clinching
- ○ Orthodontic Treatment
- ○ Problems opening / closing mouth

Please list anything else not mentioned above regarding your dental history: ______________________________

Medical History

1. When was your last medical checkup? ____
2. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? ○ No ○ Yes
   - If yes, please list: ____

     ____
3. Do you have any allergies (drugs / foods)? ○ No ○ Yes. Please list ______________________________
4. Do you smoke or chew tobacco products? ○ No ○ Yes. How much? ______________________________
5. Do you have or have ever had any of the following? Please check.

- ○ High Blood Pressure
- ○ Osteoporosis
- ○ Seizures
- ○ Rheumatic fever
- ○ Arthritis
- ○ High Cholesterol
- ○ Bleeding disorder
- ○ Thyroid disease
- ○ Tuberculosis
- ○ Steroid therapy
- ○ Heart problem
- ○ Stroke
- ○ Liver disease
- ○ Lung disease
- ○ Kidney disease
- ○ Diabetes – Type I / Type II
- ○ AIDS / HIV
- ○ Hepatitis – Type ______________
- ○ Cancer – Type ______________
- ○ Drug / alcohol addiction

Please list anything else not mentioned above regarding your medical history: ____________________________

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

Signature ______________________________ Relation to patient ________________ Date __________________