LOWELL O. TAN, DDS, INC.
Family & Cosmetic Dentistry

Gilroy Medical Park
7880 Wren Avenue, Ste. B-122
Gilroy CA 95020
Office: 408.842.5805 Fax: 408.848.8390

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

PATIENT INFORMATION

Patient 's Name _____
Street Address _____
City/State/Zip _____
Birthdate _____ ❒ Male ❒ Female
Home Phone _____ Cell _____ Work _____
Emergency Contact _____ Phone Number _____
If patient is a student, Name of School/College _____
Person Responsible for this Account _____
How did you hear about our office? _____
Previous Dentist _____ Last Visit _____

INSURANCE INFORMATION

Name of Insured _____ Name of Insured _____
SS# _____ SS# _____
Ins. Carrier _____ Ins. Carrier _____
Group # _____ Group # _____
Employer _____ Employer _____

METHOD OF PAYMENT VISA MC CASH CHECK CARE CREDIT

PLEASE READ THE FOLLOWING

Dental Insurance: As a convenience to you, our office will submit the necessary forms to your insurance company. **Estimates** are provided to you and are used as guidelines only and are subject to change if you have claims pending with your insurance for treatment pending with other providers. The patient is the responsible party for all services rendered **at the time of treatment.**

Payment: We gladly accept **Cash, Check, Visa, MasterCard, and Care Credit.**
****Any remaining balance that insurance does not cover must be paid within the timeline agreed upon between the patient and office. Any balance that goes beyond 120 days may incur finance charges and/or be sent to collections.**

Missed appointments: Our office requires a 24 hour notice for any cancellation of an appointment. There may be a charge of $40.00 **per scheduled hour** if notice is not received or if you do not show up for your appointment.

I hereby acknowledge that a copy of this practice's **Notice of Privacy Practices** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice. Yes/No (Circle One) _____ (initial)

I hereby acknowledge that a copy of this practice's **Dental Materials Fact Sheet** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. _____ (initial)

BENEFICIARY AGREEMENT

I authorize and request my insurance company to pay directly to the dentist any insurance benefits otherwise payable to me. I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether paid by insurance or not.

_____ _____

Patients signature (or parent/guardian of minor patient) **Date**

MEDICAL HISTORY

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ❒ Excellent ❒ Good ❒ Fair ❒ Poor

DO YOU HAVE or HAVE YOU EVER HAD:

	YES	NO
1. hospitalization for illness or injury	❒	❒
2. and allergic reaction to		
❒ aspirin, ibuproben, acetaminophen, codeine		
❒ penicillin		
❒ erythromycin		
❒ tetracycline		
❒ sulfa		
❒ local anesthetic		
❒ fluoride		
❒ metal (nickel, gold, silver, _____)		
❒ latex		
❒ other _____		
3. heart problems, or cardiac stent within the last six months	❒	❒
4. history of infective endocarditis	❒	❒
5. artificial heart valve, repaired heart defect (PFO)	❒	❒
6. pacemaker or implantable defibrillator	❒	❒
7. artificial prosthesis (heart valve or joints)	❒	❒
8. rheumatic or scarlet fever	❒	❒
9. high or low blood pressure	❒	❒
10. a stroke (taking blood thinners)	❒	❒
11. anemia or other blood disorder	❒	❒
12. prolonged bleeding due to a slight cut (INR>3.5)	❒	❒
13. emphysema, shortness of breath, sarcoidosis	❒	❒
14. tuberculosis, measles, chicken pox	❒	❒
15. asthma	❒	❒
16. breathing or sleep problems (i.e. sleep apnes, snoring, sinus)	❒	❒
17. kidney disease	❒	❒
18. liver disease	❒	❒
19. jaundice	❒	❒
20. thyroid, parathyroid disease, or calcium deficiency	❒	❒
21. hormone deficiency	❒	❒
22. high cholesterol or taking statin drugs	❒	❒
23. diabetes (HbA1c=)	❒	❒
24. stomach or duodenal ulcer	❒	❒
25. digestive disorders (i.e. celiac disease, gastric reflux)	❒	❒
26. osteoporosis/osteopenia (i.e. taking bisphosphonates)	❒	❒
27. arthritis, rheumatoid arthritis, lupus	❒	❒
28. glaucoma	❒	❒
29. contact lenses	❒	❒
30. head or neck injuries	❒	❒
31. epilepsy, convulsions (seizures)	❒	❒
32. neurologic disorders (ADD/ADHD, prion disease)	❒	❒
33. viral infections and cold sores	❒	❒
34. any lumps or swelling in the mouth	❒	❒
35. hives, skin rash, hay fever	❒	❒
36. STI/STD	❒	❒
37. hepatitis (type)	❒	❒
38. HIV/AIDS	❒	❒
39. tumor, abnormal growth	❒	❒
40. radiation therapy	❒	❒
41. chemotherapy, immunosuppressive	❒	❒
42. emotional problems	❒	❒
43. psychiatric treatment	❒	❒
44. antidepressant medication	❒	❒
45. alcohol/street drug use	❒	❒
ARE YOU:		
46. presently being treated of any other illness	❒	❒
47. aware pf a change in your heath in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)	❒	❒
48. taking medication for weight management (i.e. fen-phen)	❒	❒
49. taking dietary supplements	❒	❒
50. often exhausted or fatigued	❒	❒
51. experiencing frequent headaches	❒	❒
52. a smoker, smoked previously or use smokeless tobacco	❒	❒
53. considered a touchy person	❒	❒
54. often unhappy or depressed	❒	❒
55. FEMALE - taking birth control pills	❒	❒
56. FEMALE - pregnant	❒	❒
57. MALE - prostate disorders	❒	❒

Describe any current medical treatment, impeding surgery/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for additional sheet if you are taking more then 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

_____ _____

Patients signature (or parent/guardian of minor patient) **Date**