

Please use your keyboard and mouse to complete the following forms and then print the forms.  
 After printing the forms, please mail or bring them with you to your next appointment. Our mailing address is:  
 Dr. Keith Tang, 3785 Alton Parkway, Irvine, CA 92606.

### PATIENT INFORMATION

IF THIS APPOINTMENT IS FOR YOU			IF THIS APPOINTMENT IS FOR YOUR CHILD		
NAME			NAME		
SPOUSE			ADDRESS		
ADDRESS			CITY	STATE	ZIP
CITY	STATE	ZIP	HOME PHONE NO.		
HOME PHONE NO.			BIRTHDATE	AGE	MALE / FEMALE <input type="checkbox"/> <input type="checkbox"/>
CELL PHONE NO.		MARITAL STATUS	SCHOOL		
BIRTHDATE	AGE	MALE / FEMALE <input type="checkbox"/> <input type="checkbox"/>	SOCIAL SECURITY NO.		
DRIVER LICENSE	SOCIAL SECURITY NO.		IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS FILL IN THE LEFT SECTION ALSO		
GETTING TO KNOW YOU					
WHOM CAN WE THANK FOR THE REFERRAL?			PERSON TO CONTACT IN AN EMERGENCY <u>NOT LIVING WITH YOU</u>		
YOUR EMAIL ADDRESS			PHONE NUMBER		
WHERE SHOULD WE CONFIRM YOUR APPOINTMENTS?			ADDRESS		
			CITY	STATE	ZIP
ACCOUNT INFORMATION			DENTAL INSURANCE		
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT			PRIMARY CARRIER		
NAME			POLICY HOLDER'S FULL NAME		
RELATIONSHIP TO PATIENT			INSURANCE COMPANY		
ADDRESS			GROUP NUMBER		
CITY	STATE	ZIP	INSURANCE ID	EMPLOYEE NO.	
PHONE NUMBER			DATE OF BIRTH	DATE EMPLOYED	
YOU			SECONDARY CARRIER		
NAME			POLICY HOLDER'S FULL NAME		
OCCUPATION			INSURANCE COMPANY		
EMPLOYER			GROUP NUMBER		
BUSINESS ADDRESS		CITY	INSURANCE ID	EMPLOYEE NO.	
BUSINESS PHONE NO.		EXT.	DATE OF BIRTH	DATE EMPLOYED	
YOUR SPOUSE			ADDITIONAL INSURANCE INFORMATION		
NAME			FOR OFFICE USE ONLY		
OCCUPATION					
EMPLOYER					
BUSINESS ADDRESS		CITY			
BUSINESS PHONE NO.		EXT.			

PATIENT NAME
PATIENT ACCOUNT NUMBER

# DENTAL HISTORY

DENTAL ALERT
--------------

**Welcome! So that we may provide you with the best possible care, please take a moment to complete the following forms making sure that all questions have been answered to the best of your knowledge. All information is confidential.**

What is the reason for your visit today? \_\_\_\_\_  
 \_\_\_\_\_

Date of Last Dental Visit \_\_\_\_\_ Last Cleaning? \_\_\_\_\_ Last Complete Set of X-rays \_\_\_\_\_  
 What was done at your last dental visit? \_\_\_\_\_

Previous Dentist's Name \_\_\_\_\_ Address \_\_\_\_\_  
 Telephone Number \_\_\_\_\_

How often do you have dental exams or cleanings? \_\_\_\_\_  
 How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_  
 What other dental aids do you use? (Braun, Sonicare, toothpicks, etc.) \_\_\_\_\_

Do you have any dental problems? If yes, please describe \_\_\_\_\_

**Are any of your teeth sensitive to:**

	Yes	No
Hot or cold	<input type="checkbox"/>	<input type="checkbox"/>
Sweets	<input type="checkbox"/>	<input type="checkbox"/>
Biting or Chewing	<input type="checkbox"/>	<input type="checkbox"/>

**Have you experienced:**

	Yes	No
Clicking or popping of your jaw?	<input type="checkbox"/>	<input type="checkbox"/>
Pain in your jaw joint, side of face or ear?	<input type="checkbox"/>	<input type="checkbox"/>
Sore or tired jaws, especially in the morning?	<input type="checkbox"/>	<input type="checkbox"/>

**Have you noticed:**

	Yes	No
Mouth odor or bad taste?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing on either side of your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Gums that bleed or hurt?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed any loose teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Areas where food tends to become caught in between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
If yes where? _____		

**Have you ever had:**

	Yes	No
Orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Oral Surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Periodontal Treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Your teeth ground or the bite adjusted?	<input type="checkbox"/>	<input type="checkbox"/>
A nightguard or other removable appliance?	<input type="checkbox"/>	<input type="checkbox"/>
A serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please describe _____		

**Do you:**

	Yes	No
Clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Smoke/chew tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
Hold foreign objects with your teeth (pencils, pipes, pins, nails, fingernails, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Use currently or have you ever used a hard or medium toothbrush?	<input type="checkbox"/>	<input type="checkbox"/>
Feel anxious about having dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have memories from an upsetting dental experience? If yes, please describe: _____	<input type="checkbox"/>	<input type="checkbox"/>

**Smile Evaluation:**

	Yes	No
Are you satisfied with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like whiter teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like straighter teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Are there spaces that you would like closed?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have chipped, protruding, or hidden teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have old fillings or old dental work you don't like looking at?	<input type="checkbox"/>	<input type="checkbox"/>
Is there anything else you would like to change in your smile? If yes, please explain _____	<input type="checkbox"/>	<input type="checkbox"/>

**Is there anything else about your dental history or preferences that you would like us to know?** Yes No  
 If yes, please describe \_\_\_\_\_

