PETER CHUNG DDS — 7030 35TH AVENUE NE • SEATTLE WASHINGTON 98115 • (206) 526-5600 • FAX (206) 525-0933

PATIENT INFORMATION (This information is necessary for our files and your health and will be considered CONFIDENTIAL)

Patient's Last Name _____ Patient's First Name _____ Middle Initial _____ Dr. ○ Mr. ○ Mrs. ○ Ms. ○ Miss ○ Child ○

Res. Tel. ( ) _____ Cell ( ) _____ Work ( ) _____ Birth date _____

Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

Employer's Address _____ City _____ State _____ Zip _____

SS# _____ Driver's License# _____ Email _____

Spouse _____ SS# _____ Birth date _____

Spouse's Employer _____ Bus. Tel. ( ) _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Person Responsible for Account _____

Primary Ins. Name _____

Ins. Address _____

Subscriber's Name _____ Birth date _____

Group # _____

SS # _____

Secondary Ins. Name _____

Ins. Address _____

Subscriber's Name _____ Birth date _____

Group # _____

SS # _____

MEDICAL HISTORY

1 Are you in good health? ..... Yes No

2 Date of last physical examination _____

3 ARE YOU UNDER THE CARE OF A PHYSICIAN? ..... Yes No

If so, what is the condition being treated? _____

4 Have you ever had any serious illness or operation? ..... Yes No

If so, what illness or operation? _____

5 Have you ever been hospitalized? ..... Yes No

If so, what was the problem? _____

6 ARE YOU TAKING ANY DRUGS OR MEDICINE? ..... Yes No

Please list below _____

7 ARE YOU SENSITIVE OR ALLERGIC TO ANY DRUGS? ..... Yes No

If so, what? _____ Sulfa Drugs ☐ Codeine ☐ Aspirin ☐ Penicillin ☐ Antibiotics ☐

Name of Physician _____

Phone _____

Address _____

Former Dentist _____

Address _____

In case of emerg. call _____

Phone _____

Address _____

8 DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anemia
- ☐ Asthma or Hay Fever
- ☐ Alcoholism
- ☐ Cancer
- ☐ Diabetes
- ☐ Drug Dependency
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting Spells or Seizures
- ☐ Heart Ailments/Murmurs
- ☐ Head Injuries
- ☐ Hepatitis, Jaundice, or Liver Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Kidney Disease
- ☐ Herpes Type 1 or 2
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Radiation Treatment of any kind
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Rheumatism or Arthritis
- ☐ Stroke
- ☐ Stomach Ulcers
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Venereal Disease

9 Do you wear a cardiac pacemaker? ..... Yes No

10 Have you had heart surgery or heart valve replacement? ..... Yes No

11 Have you had surgical replacement of diseased blood vessels with artificial prosthesis? ..... Yes No

12 Have you had surgical replacements of joints with artificial prostheses (hip, knee, etc.)? ..... Yes No

13 How long since last dental X-rays of your entire mouth? _____/_____/_____

14 How long since last dental treatment? _____/_____/_____ Date of last cleaning? _____/_____/_____

15 HAVE YOU EVER HAD ANY UNFAVORABLE REACTION FROM A LOCAL ANESTHETIC? ..... Yes No

16 Do you have any disease, condition or problem not listed above that you think I should know about? ..... Yes No

If so, explain _____

17 (Women) are you pregnant? ..... Yes No

CONSENT FOR TREATMENT: I hereby authorize to the dentist(s) in charge of the care of the patient whose name appears on this form to administer an treatment; or to administer any anesthetics, and to perform such dental operations or procedures as may be deemed necessary or advisable in the diagnosi and treatment to this patient.

SIGNED _____ DATE _____

NOTES _____

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Seattle, WA 98115
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206-526-5600
206-525-0933 - fax

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. Please ask us for a copy of our Notice of Privacy Practices to read the document in its entirety.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices, you may refuse to sign this acknowledgement:

Print Name: _____

Signature: _____ Date:_____

For office use only:

We attempted to obtain written acknowledgment of our Notice of Privacy Practices, but were acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited us from obtaining the acknowledgement

_____Other (please specify):

CONSENT TO FORWARD X-RAYS.

Authorization to forward x-rays at your request or the request of a specified dentist or specialist.

Print Name: _____

Signature: _____ Date:_____