Linh Bauer, DDS

1953 Hamilton Ave.
San Jose, CA 95125
408-371-5700

www.LinhBauerDDS.com

NEW PATIENT REGISTRATION

Date: _____

1 About You

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.

First Name: _____ **Middle Inital:** _____ **Last Name:** _____

Preferred Name: _____ **Birthdate:** _____ **SS#:** _____

Sex: ❑ Male ❑ Female **Status:** ❑ Single ❑ Married ❑ Child ❑ Widowed ❑ Divorced

Address: _____ **Address 2:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Email Address:** _____

Occupation: _____ **Referred By:** _____
FIRST MI LAST TITLE

Preferred Contact Method: ❑ Home Phone ❑ Cell Phone ❑ Work Phone ❑ Email

Student: ❑ No ❑ Full Time ❑ Part Time **School Name:** _____

Person to contact for Emergency: _____ **Phone:** _____

Preferred Payment Method: ❑ Cash ❑ Check ❑ Credit Card

2 Insurance Information

PRIMARY INSURANCE

Relation: _____

Employer: _____

Bus. Address: _____

City: _____ **State:** _____ **Zip:** _____

Insurance Co. Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone #: _____

Insured's Name: _____
FIRST MI LAST

Address: _____

Address 2: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **DOB:** _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #)**:** _____

Do you belong to a PPO or HMO?: ❑ Yes ❑ No

SECONDARY INSURANCE

Relation: _____

Employer: _____

Bus. Address: _____

City: _____ **State:** _____ **Zip:** _____

Insurance Co. Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone #: _____

Insured's Name: _____
FIRST MI LAST

Address: _____

Address 2: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **DOB:** _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #)**:** _____

Do you belong to a PPO or HMO?: ❑ Yes ❑ No

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3 Dental Information

Reason for visit: ❑ Exam ❑ Emergency ❑ Consultation ❑ Other: _____

Are you in pain?: ❑ No ❑ Yes **How Long?:** _____

Please indicate any of the following problems:

❑ Discomfort, clicking or popping in jaw
❑ Red, swollen or bleeding gums
❑ Sensitive tooth, teeth or gums
❑ Blisters/Sores in or around the mouth
❑ Teeth grinding
❑ Lost/Broken Filling(s)
❑ Broken/Chipped tooth
❑ Ringing in Ears
❑ Locking Jaw
❑ Stained teeth
❑ Bad breath
❑ Other: _____

Do you require pre-medication?: ❑ Yes ❑ No ❑ Don't know

Previous Dentist: _____ **Phone:** _____

How would you rate your smile?: (Worst) ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 (Best)

4 Health History

Have you ever had any of the following diseases or medical conditions or procedures?:

❑ Abnormal Bleeding
❑ Alcohol / Drug Abuse
❑ Anemia
❑ Arthritis
❑ Artificial Bones/Joints
❑ Asthma
❑ Blood Transfusion
❑ Cancer/Chemotherapy
❑ Colitis
❑ Congenital Heart Defect
❑ Diabetes
❑ Difficulty Breathing
❑ Emphysema
❑ Epilepsy
❑ Fainting Spells
❑ Frequent Headaches
❑ Glaucoma
❑ Hay Fever
❑ Heart Attack
❑ Heart Murmur
❑ Heart Surgery
❑ Hemophilia
❑ Hepatitis
❑ Herpes/Fever Blisters
❑ High Blood Pressure
❑ HIV+/AIDS
❑ Joint Replacement
❑ Kidney Problems
❑ Liver Disease
❑ Low Blood Pressure
❑ Lupus
❑ Pacemaker
❑ Seizures
❑ Shingles
❑ Tuberculosis (TB)
❑ Ulcers
❑ Venereal Disease
❑ Others: _____

Allergies: ❑ Aspirin ❑ Codeine ❑ Penicillin ❑ Amoxicillin ❑ Tetracycline ❑ Dental Anesthetics ❑ Sulfa Drugs ❑ Latex ❑ Other: _____

What medications are you taking or have taken?:

❑ Accutane
❑ Actonel
❑ Amoxicillin
❑ Aspirin
❑ Atenolol
❑ Bisphosphonates
❑ Claritin
❑ Cortisone (Steroids)
❑ Coumadin
❑ Darvocet-N
❑ Fen-Phen
❑ Flonase
❑ Fosamax
❑ Insulin
❑ Lovastatin
❑ Metformin
❑ Motrin
❑ Paxil
❑ Penicillin
❑ Plavix
❑ Prevacid
❑ Prozac
❑ Redux
❑ Tetracycline
❑ Valium
❑ Vicodin
❑ Zoloft
❑ Others (including herbal medicines): _____

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5 Medical History

Please describe your current physical health: ❑ Good ❑ Fair ❑ Poor

Have you lost or gained more than 10 pounds in the past year? ❑ Yes ❑ No

Do you have a prosthetic joint/implant? ❑ Yes ❑ No

Have you had a heart valve replacement or vascular graft? ❑ Yes ❑ No

Do you smoke? ❑ Yes ❑ No **If yes, how long?:** _____

Do you chew tobacco? ❑ Yes ❑ No **If yes, how long?:** _____

Do you wear contact lenses? ❑ Yes ❑ No

Is there a Family History of: Cancer? ❑ Yes ❑ No **Diabetes?** ❑ Yes ❑ No

Heart Disease? ❑ Yes ❑ No **Anesthetic Problems?** ❑ Yes ❑ No

Are you currently under the care of a physician?: ❑ Yes ❑ No **If yes, reason?:** _____

Physician's Name: _____ **Phone:** _____

Have you been hospitalized or required emergency care in the last 5 years? ❑ Yes ❑ No

If yes, please explain: _____

6 For Women Only

This section is for women only, men continue below. Women, continue below when you have completed this section.

Are you pregnant?: ❑ Yes ❑ No **If yes, expected delivery date:** _____

Are you nursing? ❑ Yes ❑ No **Are you taking birth control pills?** ❑ Yes ❑ No

7 Consent for Services

This section will be filled out and signed when you come to the office.

I acknowledge that the information that I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my status. I authorize the dental staff to perform the neccessary services I may need. I assign the Doctor all insurance benifits. I understand that I am responsible for payment of service rendered, any deductible, and co-payment that my insurance does not cover.

Patient's Signature: _____ **Date:** _____

Parent/Responsible Party's Signature: _____ **Relationship:** _____

By signing below, I only acknowledge that I have received a copy of this office's **HIPAA Notice of Privacy Practices**.

Patient's Signature: _____ **Date:** _____