Rose City Dental Care

John J. Lee, DDS - Tae W. Lee, DDS

PATIENT INFORMATION

Patient Name:_____Preferred Name:_____Sex:M__F__ Birth Date:_____

Address:_____Apt #_____City_____State_____Zip_____

SSN:_____ Home #:_____ Cell #:_____

Email:_____ Do you accept text message appointment reminders? ☐Yes ☐No

Employed By:_____Occupation:_____Work #:_____

Whom may we thank for referring you?/How did you find our office?:_____

Emergency Contact Name:_____Relationship to Patient:_____Phone #:_____

PERSON FINANCIALLY RESPONSIBLE (IF DIFFERENT FROM PATIENT)

Name:_____Relationship to Patient:_____Birth Date:_____

Billing Address:_____Apt#_____City:_____ State_____ Zip_____

SSN:_____Home #:_____ Cell #:_____

MEDICAL HISTORY

Medical Dr's Name_____Office phone_____Date of last exam_____

Have you ever had any of the following? (check all boxes that apply):

☐ High Blood Pressure	☐ Heart Disease	☐ Chest Pains	Comments
☐ Heart Attack	☐ Cardiac Pacemaker	☐ Easily Winded	
☐ Rheumatic Fever	☐ Heart Murmur	☐ Stroke	
☐ Swollen Ankles	☐ Angina	☐ Hay Fever/Allergies	
☐ Fainting/Seizures	☐ Frequently Tired	☐ Tuberculosis	
☐ Asthma	☐ Anemia	☐ Radiation Therapy	
☐ Low Blood Pressure	☐ Emphysema	☐ Glaucoma	
☐ Epilepsy/Convulsions	☐ Cancer	☐ Recent Weight Loss/Gain	
☐ Leukemia	☐ Arthritis	☐ Liver Disease	
☐ Diabetes	☐ Joint Replacement or Implant	☐ Heart Trouble	
☐ Kidney Diseases	☐ Hepatitis/Jaundice	☐ Respiratory Problems	
☐ AIDS or HIV Infection	☐ Sexually Transmitted Diseases	☐ Other_____	
☐Thyroid Problem	☐ Stomach Trouble/Ulcers		

1. Are you under any medical treatment now? ☐ Yes ☐ No
   If yes, for what?_____
   _____
2. Have you ever been hospitalized for any surgical operation or serious illness? ☐ Yes ☐ No
3. Are you taking any medication(s) including non-prescription medicine? ☐ Yes ☐ No
   If yes, what medications are you taking? _____
   _____
4. Do you use tobacco?☐ Yes ☐ No Alcohol?☐ Yes ☐ No
5. Do you have any drug allergies or have you ever had an allergic reaction to any medication or anesthesia? ☐ Yes ☐ No
   If yes, what?_____
6. (Women)Are you pregnant or think you may be pregnant? ☐ Yes ☐ No
7. (Women)Are you nursing? ☐ Yes ☐ No
8. (Women)Are you taking birth control? ☐ Yes ☐ No

Name of your previous dentist?:_____

Date of last dental exam?:_____

Date of last dental x-ray?:_____

Please place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad Breath	☐Yes ☐No
Bleeding Gums	☐Yes ☐No
Blisters on lips or mouth	☐Yes ☐No
Chewing on one side of the mouth	☐Yes ☐No
Clicking or popping jaw	☐Yes ☐No
Dry mouth	☐Yes ☐No
Food collection between teeth	☐Yes ☐No
Grinding teeth	☐Yes ☐No
Gums swelling or tenderness	☐Yes ☐No
Jaw pain or tenderness	☐Yes ☐No
Lip or cheek biting	☐Yes ☐No
Loose teeth or broken fillings	☐Yes ☐No
Mouth breathing	☐Yes ☐No
Pain when brushing	☐Yes ☐No
Braces	☐Yes ☐No
Periodontal treatment	☐Yes ☐No
Gum disease	☐Yes ☐No
Sensitivity to hot/cold	☐Yes ☐No
Sensitivity to sweet/sour	☐Yes ☐No
Mouth sores	☐Yes ☐No
Sensitivity when biting	☐Yes ☐No

How often do you brush?:_____

How often do you floss?:_____

To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health and that it is my responsibility to inform the office of any changes in my health.

Signature of Patient or Parent/Guardian:_____**Date:**_____