



HUAYANG JOHN WU, D.D.S., M.S.
 1919 O'FARRELL ST, STE. 1, SAN MATEO, CA 94403
 (650) 571-6666

Patient: _____ Birthday: _____
First Name Middle Init. Last Name Pref. Name Month / Day / Year

Address: _____ Cell Phone: _____
 _____ Home Phone: _____
 City: _____ State / Zip: _____ Work Phone: _____

Sex: Male Female Marital: Married Single Unknown

Soc. Sec. #: _____ Driver License: _____ E-Mail: _____

EMERGENCY CONTACT Name: _____ Phone #: _____ Relationship: _____

Who may we thank for your referral: _____

Reason for today's visit/chief concern: _____

Primary Dental Insurance's Policy Holder: _____	Relationship: _____
Ins. Company: _____	Employer: _____
Soc. Sec. #: _____	Ins. ID #: _____
	Birthday: _____

Secondary Dental Insurance's Policy Holder: _____	Relationship: _____
Ins. Company: _____	Employer: _____
Soc. Sec. #: _____	Ins. ID #: _____
	Birthday: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, would have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Physician's Name: _____ Physician's Phone #: _____ Physician's Fax #: _____

Are you under a physician's care now? Yes No If yes, please explain: _____
 Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
 Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
 Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
 Do you take, or have you taken, Phen-Fen or Redux? Yes No
 Are you required to premedicate prior to dental procedures? Yes No If yes, please explain: _____
 Are you on a special diet? Yes No
 Do you use tobacco? Yes No
 Do you use controlled substances? Yes No
 Do you take, or have you taken the following osteoporosis Yes No If yes, please indicate when did you start and/or stop:
 supplements: Fosamax, Actonel, Boniva, Any others: _____

Women: Are you Pregnant/Trying to get pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Taking oral contraceptives? <input type="checkbox"/> Yes <input type="checkbox"/> No Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Are you allergic to any of the following? <input type="checkbox"/> Aspirin <input type="checkbox"/> Penicillin <input type="checkbox"/> Codeine <input type="checkbox"/> Acrylic <input type="checkbox"/> Metal <input type="checkbox"/> Latex <input type="checkbox"/> Local Anesthetics <input type="checkbox"/> Other If yes, please explain: _____
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Do you have, or have you had, any of the following?

AIDS/HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anaphylaxis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B or C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easily Winded	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No

Artificial Joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spina Bifida	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting Spells/Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Genital Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attach/Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sores/Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pace Maker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Trouble/Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

FORMER DENTIST:

(City / State) _____ Phone #: _____

Date of Last Visit: _____ Date of Last Dental X-rays: _____

Current Oral Hygiene:

Brush (Manual or Electric): _____ Mouth-Rinse: _____

Floss: _____ Other: _____

HAVE YOU EVER HAD AN ADVERSE REACTION DURING DENTAL TREATMENT? Yes No If yes, please explain: _____

COMMENTS:

Please feel free to discuss any information you do not wish to document here.

- Please be advised that as a courtesy we will process your insurance claim for you. Patients are responsible for all dental fees at the time of service regardless of insurance coverage.
- 24-hour cancellation notice is required for all appointments or a service fee of \$50 will be applied.
- Payment Methods: Cash / Check / Credit Card / CareCredit Card

Consent For Treatment

I do hereby authorize Dr. Huayang John Wu and associates to administer such anesthetics and perform such treatment as may be necessary for the above named patient. I am also aware that the office charges a late fee of 18% for any outstanding balances over 30 days.

Signed: _____ Date: _____

Reviewed by Staff: _____ Date: _____

Reviewed by Doctor: _____ Date: _____

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	CHANGES TO HEALTH HISTORY	PATIENT'S SIGNATURE	BP	PULSE	REVIEWED BY
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____