Ivy Chan, DDS
2041 Polk Street, Suite G, San Francisco, CA 94109
(415) 885-5255

Medical History

Physician _____ *Office Phone* _____ *Date of Last Exam* _____

	Yes	No
1. Are you under the care of a Medical Doctor?	●	●
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	●	●
If yes, please explain_____		
3.a) Are you taking any medication(s) Including non-prescription medicine?	●	●
If yes, what medications are you taking_____		
b) Have you ever taken the drug Phen-Fen or Redux?	●	●
4. Do you use tobacco?	●	●
5. Do you use controlled substances?	●	●
6. Are you wearing contact lenses?	●	●

	Yes	No
8. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (eg. Novocaine)	●	●
Penicillin or any other Antibiotics	●	●
Sulfa Drugs	●	●
Iodine	●	●
Aspirin	●	●
Any Metals (eg. Nickel, mercury etc.)	●	●
Latex Rubber	●	●
Other (please list) _____		
9. Women Only:		
a) Are you pregnant or think you may be pregnant?	●	●
b) Are you nursing?	●	●
c) Are you taking oral contraceptives?	●	●

7. Do you have or have had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	●	●	Heart Disease	●	●	Chest Pains	●	●
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	●	●
Leukemia	●	●	Arthritis	●	●	Liver Disease	●	●
Diabetes	●	●	Joint Replacement or Implant	●	●	Artificial Heart Valve	●	●
Kidney Diseases	●	●	Hepatitis/Jaundice	●	●	Respiratory Problems	●	●
AIDS or HIV infection	●	●	Sexually transmitted Disease	●	●	Other_____		
Thyroid Problem	●	●	Stomach Troubles/Ulcers	●	●			

Dental History

Previous Dentist _____ *Date of Last Exam* _____ *Date of Last X-ray* _____
(Name) (Phone)

Oral hygiene aids used _____ *Times a day you brush* _____ *Times a week you floss* _____

Do you have the following :

	Yes	No		Yes	No
Painful teeth	●	●	Difficult extraction(s) in the past	●	●
Teeth sensitive to hot /cold	●	●	Prolonged bleeding after extraction	●	●
Teeth sensitive to sweet/sour	●	●	Full or Partial Denture	●	●
Red, swollen or bleeding gum	●	●	Stained Teeth	●	●
Blisters/Sores in or around mouth	●	●	Loose teeth	●	●
Food trapped between teeth	●	●	Do you like your smile	●	●
Teeth grinding/Clenching	●	●	Do you want whiter teeth	●	●

Have you ever experienced any of the following problem in your jaws ?

	Yes	No
Clicking	●	●
Pain(joint, ear, side of face)	●	●
Difficulty in opening or closing	●	●
Difficulty in Chewing	●	●
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	●	●

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. I authorize Dr. Ivy Chan and her staff to perform any necessary services needed during diagnosis and treatment. I also authorize Dr. Ivy Chan to release any information required to process insurance claims. I authorize and request my insurance company to pay directly to Dr. Ivy Chan insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less that the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that full payment or co-payment is required at the time of service unless other arrangements have been made and that finance charge and interest will be charged if the account is not paid within 90 days after the date of service. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

X _____ *Date* _____
Signature of patient (or parent if minor)