KEITH M. ABE DDS
QUYNH K. ABE DDS

Please fill out this form completely.

1. ABOUT YOU

Today's date: ______________________

Name: ______________________
LAST FIRST MIDDLE

I prefer to be called: ______________________

E-mail Address: ______________________

Birthdate: __________ SSN: __________

Home Address: ______________________
STREET APT / CONDO #

____
CITY STATE ZIP

Status: Single Married Divorced Widowed Separated

Phone (Home / Cell): ______________________

Phone (Work): ______________________
EXT DL#

Employer: ______________________

Employer's Address: ______________________

How long there?: ______________________

Occupation: ______________________

OK to confirm electronically? (Text / Email): ☐Yes ☐No

Whom may we thank for referring you?: ______________________

Other family members seen by us: ______________________

(Previous / Present) Dentist: ______________________

____

Last Visit Date: ______________________

2. SPOUSE INFORMATION

His / Her name: ______________________

Employer: ______________________

Birthdate: __________ SSN: __________

Phone (Work): __________ Driver's License #: __________

Person Responsible for account: ______________________

Phone (Home): __________ Phone (Work): __________

Billing Address: ______________________

Relation: __________ SSN: __________

Employer: __________ DL#: __________

3. INSURANCE COVERAGE

Dental Coverage: ☐Yes ☐No

Insurance Co. Name: ______________________

Insurance Co. Address: ______________________

Insurance Co. Phone #: ______________________

Group # (Plan, Local or Policy #): ______________________

Insured's Name: ______________________

Relation: ______________________

Insured's Birthdate: ______________________

Insured's ID: ______________________

Insured's employer: ______________________

In the event of an emergency, is there someone who lives near you that we should contact?: ______________________

His / Her name: ______________________

Relation: ______________________

Phone (Home / Cell): ______________________

4. MEDICAL HISTORY

Do you have a personal physician?: ☐Yes ☐No

Physician's Name: ______________________

Phone #: ______________________

Date of last visit: ______________________

Are you currently under the care of a physician?: ☐Yes ☐No

Please explain: ______________________

Your current physical health is: ☐Good ☐Fair ☐Poor

Are you taking any prescription / over-the -counter or herbal supplement drugs?: ☐Yes ☐No

Please list each one: ______________________

Have you ever taken Fosamax or any other bisphosphonates for osteoporosis?: ☐Yes ☐No

Have you been told that you snore or hold your breath or stop breathing while sleeping, or wake up gasping for breath?: ☐Yes ☐No

For Women: Are you using a prescribed method of birth control?: ☐ Yes ☐ No

Are you pregnant?: ☐ Yes ☐ No Week #: ____________ weeks

Are you nursing?: ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

☐ Yes ☐ No Abnormal Bleeding
☐ Yes ☐ No Alcohol / Drug Abuse
☐ Yes ☐ No Anemia
☐ Yes ☐ No Arthritis
☐ Yes ☐ No Artifical Bones / Joints / Valves
☐ Yes ☐ No Asthma
☐ Yes ☐ No Blood Transfusion
☐ Yes ☐ No Cancer / Chemotherapy
☐ Yes ☐ No Colitis
☐ Yes ☐ No Congenital Heart Defect
☐ Yes ☐ No COVID-19
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Difficulty Breathing
☐ Yes ☐ No Emphysema
☐ Yes ☐ No Epilepsy
☐ Yes ☐ No Fainting Spells
☐ Yes ☐ No Frequent Headaches
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Hay Fever
☐ Yes ☐ No Heart Attack
☐ Yes ☐ No Heart Murmur
☐ Yes ☐ No Heart Surgery
☐ Yes ☐ No Hemophilia
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No Herpes / Fever Blisters
☐ Yes ☐ No HIV+ / AIDS
☐ Yes ☐ No Hospitalized for Any Reason
☐ Yes ☐ No Kidney Problems
☐ Yes ☐ No Liver Disease
☐ Yes ☐ No Low Blood Pressure
☐ Yes ☐ No Mitral Valve Prolapse
☐ Yes ☐ No Pacemaker
☐ Yes ☐ No Psychiatric Treatment
☐ Yes ☐ No Radiation Treatment
☐ Yes ☐ No Rheumatic /Scarlet Fever
☐ Yes ☐ No Seizures
☐ Yes ☐ No Shingles
☐ Yes ☐ No Sickle Cell Disease/ Traits
☐ Yes ☐ No Sinus Problems
☐ Yes ☐ No Stroke
☐ Yes ☐ No Thyroid Problems
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Ulcers
☐ Yes ☐ No Venereal Disease

Please list any serious medical condition(s) that you have ever had: ____________________

Are you allergic to any of the following?

☐ Yes ☐ No Aspirin
☐ Yes ☐ No Codeine
☐ Yes ☐ No Dental Anesthetics
☐ Yes ☐ No Erythromycin
☐ Yes ☐ No Jewelry
☐ Yes ☐ No Latex
☐ Yes ☐ No Metals
☐ Yes ☐ No Penicillin
☐ Yes ☐ No Siulfites
☐ Yes ☐ No Tetracycline

Please list any other drugs / materials that you are allergic to:

____

Why have you come to the dentist today?

____

Do you require antibiotics before dental treatment?: ☐ Yes ☐ No

Are you currently in pain?: ☐ Yes ☐ No

Do your gums ever bleed?: ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work?: ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ/TMD): ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile?: ☐ Yes ☐ No

Do you wish your teeth were straighter?: ☐ Yes ☐ No

Would you like whiter teeth?: ☐ Yes ☐ No

Do you grind or clench your teeth at night?: ☐ Yes ☐ No

How many times a week do you floss? ____________

How many times a day do you brush? ____________

Type of bristles?: ☐ Yes ☐ No

Do you smoke or use tobacco in any other form, or smoke any other substances?: ☐ Yes ☐ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibvility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

____
signature date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

If you have dental insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

____
signature date

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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