Tony I. Kuo, D,D.S., Inc.
Atrium Cosmetics &
Restorative Dentistry
bring out the smile within you

1901 Newport Blvd.
Suite 208
Costa Mesa, CA 92627

Tel 949.650.5068
Fax 949.650.0334

PATIENT REGISTRATION AND HISTORY

PATIENT INFORMATION

Name: _____ Phone number: _____
last name first name middle

Sex: ___ M ___ F Age: _____

Home address: _____
street

Date of Birth:_____

_____ Soc. Sec. No. _____ - _____ - _____
city zip

E-Mail: _____ Work Number: _____

Business Address: _____ Employed By: _____
street

_____ Occupation: _____
city zip

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____ Phone Number: _____

DENTAL INSURANCE INFORMATION

Primary Insurance:
Name of Insurance Company: _____ Phone Number: _____

Member Name: _____ Relation to Patient: _____
last name first name middle

Member Soc. Sec. #: _____ DOB: _____ Group Number: _____
plan or policy no.

Member's Employer: _____

Employer's Address: _____ Phone Number: _____
street

_____
city zip

Secondary Insurance: (If Applicable)
Name of Insurance Company: _____ Phone Number: _____

Member Name: _____ Relation to Patient: _____
last name first name middle

Member Soc. Sec. #: _____DOB:_____ Group Number: _____
plan or policy no.

Member's Employer: _____

Employer's Address: _____ Phone Number: _____
street

_____
city zip

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DENTAL HISTORY

Reason for today's Visit: _____

Are you currently in Pain?	YES	NO
Are your teeth sensitive to (circle)?	COLD	HOT
Do your gums ever bleed?	YES	NO
Do you have history of smoking or are currently smoking?	YES	NO
Do you need pre-medication prior to treatment?	YES	NO

How often do you floss and brush? _____

Previous Family Dentist: _____ Phone number: _____

MEDICAL HISTORY

AIDS	Yes	No	Fainting or dizziness	Yes	No	Psychiatric Care	Yes	No
Anemia	Yes	No	Glaucoma	Yes	No	Radiation Treatment	Yes	No
Arthritis	Yes	No	Headaches	Yes	No	Respiratory Disease	Yes	No
Artificial Heart Valves	Yes	No	Heart Murmur	Yes	No	Rheumatic Fever	Yes	No
Artificial Joints	Yes	No	Heart Problem	Yes	No	Scarlet Fever	Yes	No
Asthma	Yes	No	Hepatitis	Yes	No	Shortness of Breath	Yes	No
Back Problem	Yes	No	Type: _____			Sinus Trouble	Yes	No
Bleeding abnormally			Herpes	Yes	No	Skin Rash	Yes	No
with extraction	Yes	No	High Blood Pressure	Yes	No	Special Diet	Yes	No
Blood Disease	Yes	No	History of Phen-Fen	Yes	No	Stroke	Yes	No
Cancer:	Yes	No	HIV Positive	Yes	No	Swelling of Feet or		
Type: _____			Jaundice	Yes	No	Ankles	Yes	No
Chemical dependency	Yes	No	Jaw Pain	Yes	No	Swollen Neck Glands	Yes	No
Chemotherapy	Yes	No	Kidney Disease	Yes	No	Thyroid Problem	Yes	No
Circulatory	Yes	No	Liver Disease	Yes	No	Tonsillitis	Yes	No
Cortisone Treatment	Yes	No	Low Blood Pressure	Yes	No	Tuberculosis	Yes	No
Diabetes	Yes	No	Mitral Valve Prolapse	Yes	No	Ulcer	Yes	No
Emphysema	Yes	No	Osteoporosis	Yes	No	Venereal Disease	Yes	No
Epilepsy	Yes	No	Pacemaker	Yes	No			

WOMEN ONLY: Are you pregnant? Yes No Due Date: _____ Are you Nursing? Yes No

Physician's Name: _____ Phone No. _____ Last Vist: _____

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

Pharmacy Name: _____

Phone number: _____

ALLERGIES (CIRCLE)

Asprin	Local Anesthetic
Barbituates (Sleeping Pills)	Penicillin
Codeine	Sulfa
Iodine	Latex

Others: _____

_____

Bisphasphonates Types (please circle all or any that you have taken)

Fosamax	Atelvia	Ostac	Any Other Type:
Boniva	Reclast	Bonefos	_____
Actonel	Zometa	Avedia	_____

All information will remain secure and confidential. **(Turn Over to Back Page)**

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ASSIGNMENT AND RELEASE

I certify that all above information are correct. This is my consent to the examination and dental treatment performed at this office. I understand and acknowledge that I am financially responsible for all charges for myself or the above named, regardless of insurance coverage. All cash patient fees, deductible and copayment are due at the time of treatment.

Insurance Claim: I hereby authorize the doctor to release all information necessary to secure insurance payment of benefits directly to my doctor. I understand and acknowledge that I am financially responsible for all charges for myself or the above named, regardless of insurance coverage. If my insurance company has not pay the office within 60 days, I will be responsible for the whole (uncollected) treatment fee. I also authorize the use of this signature on all insurance submissions.

Understanding your Dental Insurance Coverage is patient's responsibilities. Your insurance company plan administrator, insurance broker or the benefits representiative (at your place of employment) should address your questions regarding insurance coverage. Please advise that we are submitting your claim as a courtesy for our patient.

The deductible and copayments are only a best estimate at time of service. You may receive a billing statement from our office for the difference of insurance payment and actual fee. Most insurance companies offer an explanation of benefits to help answer your questions. If payment is not received 90 days after services are rendered, 10% APR will retroactively apply from the day of services rendered plus any collection costs. Your account will be forwarded to 3rd party for collection effort.

Cancellation Policy: With the high demand of our appointments, we appreciate our patients keeping their appointment and being on time. If you must reschedule your appointment, we ask you to give us at least 48 hour notice. Otherwise, $50 cancellation fee will be charge to your account.

Patient: _____ Date: _____
(signature)

Parent or Responsible Party: _____ Relation to Patient: _____
(signature)

Who may we thank for your referral:

_____

FOR OFFICE USE:

Reviewed by: Dr. _____

Date: _____