HUAYANG JOHN WU, D.D.S., INC.
1919 O'FARRELL ST, STE. 1, SAN MATEO, CA 94403, TEL: (650) 571-6666, FAX: (650) 358-9999
1702 MIRAMONTE AVE, STE. B, MOUNTAIN VIEW, CA 94040, TEL: (650) 718-5086, FAX: (650) 718-5088

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 supplements: Fosamax, Actonel, Boniva, Any others:_____	☐ Yes ☐ No	If yes, please indicate when did you start and/or stop:

Women: Are you
Pregnant/Trying to get pregnant? ☐ Yes ☐ No **Taking oral contraceptives?** ☐ Yes ☐ No **Nursing?** ☐ Yes ☐ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

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

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