



Dr. Lewis Yu/ Dr. Grace Liu
4543 Stoney Batter Rd.
Wilmington, DE 19808

Patient Information

Date _____

Name: _____ Dr. Mr. Mrs. Ms.
Address: _____ City, State, Zip _____
Telephone: H) _____ W) _____ Cell) _____ email _____
Sex M F Social Security # _____ Birthdate: _____
Employer: _____ Address: _____ Phone: _____
Spouse/ Parent Name: _____ Address: _____ Phone: _____
Full Time Student: School Name _____ State: _____ Yr. of Grad. _____
Person Responsible for Account: _____ Relationship to Patient: _____
Whom May We Thank For Referring You: _____

In Case of Emergency, Please Contact: (please specify someone not in your household)

Name: _____ Relationship: _____
Telephone: H) _____ W) _____

Insurance Information

Primary Insured

Secondary Insured

Subscriber: _____	Subscriber: _____
Address: _____	Address: _____
Telephone: _____	Telephone: _____
Birthdate: _____ Relationship to patient: _____	Birthdate: _____ Relationship to Patient: _____
SSN: _____ Subscriber ID: _____	SSN: _____ Subscriber ID: _____
Employer: _____ Group # _____	Employer: _____ Group# : _____
Dental Ins. Co: _____	Dental Ins. Co: _____

Authorization

We will reserve a space for you and /or your family member(s) in our schedule. Please advise our office within 48 hours if for whatever reasons you and/or your family members will not be able to keep the appointment. If we are not contacted within 48 hours prior to the appointment, you will be responsible for a \$25.00 fee for each appointment that was scheduled. If three appointments are missed by you and/or your family member(s) that was not properly notified, you will be dismissed as a patient.

I understand that my dental insurance is a contract between the insurance carrier and me and as such, agree that regardless of the insurance company's coverage, I am responsible for all fees incurred as a result of treatment received at All About Smiles, P.A.. I hereby authorize payment directly to All About Smiles, P.A. of the group dental benefits, otherwise payable to me. My payment (or co-payment, if there is dental insurance) is due prior to treatment.

I hereby authorize All About Smiles, P.A. to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge.

I grant consent to the dentist to the use and disclosure of protected health information to carry out treatment, payment activities, and healthcare operations. I further grant release of my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals, whether manually or electronically. A copy of the Notice of Privacy Practices has been provided to me, upon request.

As guarantor of my account, I understand that I am financially responsible for all of the fees for the dental treatment. I further agree that I have received a copy of the office financial policy and agree to its contents.

Signature _____ Date _____

Patient Name: _____ Date: _____

DENTAL HISTORY

please circle

- Do you have a specific dental problem? Describe _____ Yes No
- Do you brush and floss on a routine basis? Discuss _____ Yes No
- Do your gums ever bleed? Discuss _____ Yes No
- Do you have sensitivity to cold, hot, sweets, or biting? _____ Yes No
- Do you experience any pain in your teeth? _____ Yes No
- Do you experience blisters or sores on mouth or lips? _____ Yes No
- Do you have difficulty getting numb? _____ Yes No
- Do you like your smile? Why? _____ Yes No
- Does food catch between your teeth? Any loose teeth? _____ Yes No
- Do you want to keep your remaining teeth? _____ Yes No
- Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
- Have your past experiences in a dental office always been positive? _____ Yes No
- Do you smoke or chew tobacco? Any sores or growths in your mouth? _____ Yes No
- Do you have dental examinations on a routine basis? Last Visit _____ Yes No
- Name of previous dentist? _____
- Date of last full mouth x-rays (16 small films or panoramic) _____ Yes No

MEDICAL HISTORY

- Physician's Name _____ Phone _____ Date of Last Visit _____
- Are you under a physician's care now? Why? _____ Yes No
 - Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
 - Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
 - Have you seen an ENT (ears, nose, throat) doctor? Name _____ Yes No
 - Do you have a past history of substance abuse or drug addiction? _____ Yes No
 - Are you on a special diet? Discuss _____ Yes No
 - Women: Pregnant/Trying? _____ Taking oral contraceptives? Discuss _____ Yes No

Please check any of the conditions that apply:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Swollen Glands |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis Type ___ | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tumor or Growth |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Herpes | <input type="checkbox"/> Radiation Treatment/Chemotherapy | <input type="checkbox"/> on head or neck |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Unexplained Weight Loss |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> HIV+ | <input type="checkbox"/> Rheumatism | |
| <input type="checkbox"/> Cough, persistent or bloody | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Scarlet Fever | Women |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Are you pregnant? |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sinus Trouble | Due date _____ |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Are you Nursing? |

Do you have or have you had any disease, condition or problem not listed?

Please List all medications (prescribed or OTC), supplements, and herbs that you are taking:

ALLERGIES

- Please check if you are allergic to any of the following, including flavorings and food coloring?
- | | | | | |
|---------------------------------------|----------------------------------|---|-------------------------------------|--------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex | <input type="checkbox"/> Metals | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Barbituates | <input type="checkbox"/> Iodine | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Penicillin | |
| <input type="checkbox"/> Others _____ | | | | |

The above information is accurate and complete to the best of my knowledge. I will not hold the dentist or any member of the team responsible for errors or omissions that I may have made in the completion of this form.

Signature of Patient, Parent/Guardian if minor

Date

DATE _____

NAME _____ AGE _____ SEX _____

Are you likely to doze off or fall asleep in the following situations?

DURING THE DAY

Sitting and reading	often	sometimes	never
Watching TV	often	sometimes	never
Sitting, inactive, in public place (e.g. theatre or meeting)	often	sometimes	never
As a passenger in car for one hour	often	sometimes	never
Lying down to rest in afternoon	often	sometimes	never
Sitting and talking to someone	often	sometimes	never
Sitting quietly after lunch (without alcohol)	often	sometimes	never
In car, while stopped for a few minutes in traffic	often	sometimes	never

DURING SLEEP

Snore loudly	often	sometimes	never
Stop breathing	often	sometimes	never
Choke or struggle for breath	often	sometimes	never
Toss and turn frequently	often	sometimes	never
Grind your teeth	often	sometimes	never
Awaken with headache	often	sometimes	never
Have you had morning fatigue, fogginess, or awakened feeling un-refreshed?	often	sometimes	never

HEIGHT _____ ft. _____ inches PRESENT WEIGHT _____ lbs.

Weight gained in last 12 months _____ lbs.

Have you had an overnight sleep test? _____

What other doctors have you seen about your snoring and what did they advise?
