



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:

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