Steven K. Olsen D.D.S., Professional Corporation

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Jiahua Zhu, D.D.S.
Albert Lam, D.M.D.
Gagandeep Pandher,D.D.S.
Hebert Chan, D.D.S.

Patient Information

Patient Info. Update

_____ _____
Date Initials

_____ _____
Date Initials

Date _____

Name _____
Address _____
City _____ State _____ Zip _____
Date of Birth _____ Age _____
Male _____ Female _____
Social Security # _____
Driver's License # _____
Married _____ Single _____
Employer _____
Address _____
_____
Position _____

Cell Phone # _____
Work # _____
Home # _____
Email Address _____

Spouse / Partner Information
Name _____
Phone _____
Address _____
_____

Who may we thank for referring you? _____

If you have Dental Insurance, please provide the following information so we can assist you in billing your dental insurance carrier:

Primary Carrier

Name of Insured _____
Patient Relationship to Insured _____
SS # or Member ID_____
Insurance Carrier _____
Employer _____
Group # _____

Secondary Carrier

Name of Insured _____
Patient Relationship to Insured _____
SS # or Member ID_____
Insurance Carrier _____
Employer _____
Group# _____

General Information

Convenient Appointment Time _____
Are you available for appointments on short notice?
_____ Time of day _____
Person to contact in case of emergency:
_____
Their Telephone _____

Person Responsible for Account _____
_____
Relationship to patient _____
Driver's License # _____

<u>Please Fill Out Both Sides Of The Form</u>*

Two Embarcadero Center *San Francisco, CA 94111* *(415) 398-4400*

Medical History

Please Answer All Questions

Please circle Yes or No to the following:

			If Yes, Explain:
Rheumatic Fever	NO	YES	_____
Heart Murmur	NO	YES	_____
High Blood Pressure	NO	YES	_____
Circulation Problems	NO	YES	_____
Excessive Bleeding	NO	YES	_____
Hepatitis	NO	YES	_____
Venereal Disease	NO	YES	_____
AIDS	NO	YES	_____
Anemia	NO	YES	_____
Diabetes	NO	YES	_____
Kidney Disease	NO	YES	_____
Respiratory Disease	NO	YES	_____
Tuberculosis	NO	YES	_____
Sinus Problems	NO	YES	_____
Asthma	NO	YES	_____
Hay Fever	NO	YES	_____
Ulcers	NO	YES	_____
Arthritis	NO	YES	_____
Tumors or Growths	NO	YES	_____
Radiation Treatment	NO	YES	_____
Fainting Spells	NO	YES	_____
Nervous Disorders	NO	YES	_____
Epilepsy	NO	YES	_____
Head/Neck Injuries	NO	YES	_____
Stroke	NO	YES	_____

Are you in good health? _____
Date of last medical exam _____
Have you ever been hospitalized? _____
If yes, what was the reason _____
_____
Do you wear a cardiac pacemaker? _____
Are you under the care of a physician?
_____
If so, for what? _____
_____
Are you pregnant? _____
How many months? _____
List any drugs or chemicals you are
Sensitive to _____
Any allergies to latex? _____
List any drugs you are now taking: _____
_____
Have you ever taken Bisphosphonates? _____
_____
Have you ever taken Fen-Phen? _____
Physician's Name _____
_____
Do you have any other disease, problem
or condition that you think the Doctor
should know about? _____
_____
Do you smoke? _____ If yes, how many packs
a day and for how long? _____
Do you drink Alcohol? _____ If yes, what is
your weekly intake? _____

Dental History

(Please Answer All Questions)

When was the last time you saw a Dentist? _____
Have you ever had an unfavorable experience with a Dentist?
_____
_____
Is there anything we can do to make you feel more comfortable
While receiving treatment? _____
_____
_____
_____ Nitrous Oxide
_____ Other

When were your last set of x-rays taken? _____
Have you been instructed in the care of your gums? _____
_____

Have you been treated for periodontal (gum)
Disease? _____
Do you have any sores, blisters, or swelling
on your gums, lips, or cheeks? _____
_____
_____
Do you grind or clench your teeth? _____
_____
_____
Have you ever had popping or clicking near
near your ear when you chew? _____
Have you had orthodontic treatment?
_____
Do you, or have you had any dental disease
problems or condition that hasn't been
mentioned? _____
Please explain: _____

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I attest to the accuracy of the information on this form.

Patient or Guardian's Signature: _____ **Date:** _____
I certify that I have reviewed the medical history with the patient: _____

Doctor's Signature