

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

Steven K. Olsen, D.D.S.
Curt C. Facchino, D.D.S.
Russell S. Harris, D.D.S.
Shweta Prabhakar, D.D.S.
Pil Han, D.M.D.
Jaewoong Choi, D.D.S.
Brian R. Carr, D.D.S., M.D

H. Kashani, D.M.D., M.S., M.S.
Allen L. Hasse, D.D.S., A.B.G.D.
Nancy G. Loh, D.D.S.
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 _____

Date Initials

Name _____

Date Initials

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 # _____

Please Fill Out Both Sides Of The Form*

Two Embarcadero Center

San Francisco, CA 94111

(415) 398-4400

Medical History

Please Answer All Questions

Please circle Yes or No to the following:

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

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: _____