KEITH M. ABE DDS
QUYNH K. ABE DDS

Please fill out this form completely.

1. ABOUT YOU

Today's date: _____

Name: _____
LAST FIRST MIDDLE

Pronoun: _____

E-mail Address: _____

Birthdate: _____ SSN: _____

Home Address: _____
STREET APT / CONDO #

_____
CITY STATE ZIP

Status: Single Married Divorced Widowed Separated

Phone (Home / Cell): _____

OK to confirm electronically? (Text / Email): ☐Yes ☐No

Whom may we thank for referring you?: _____

Other family members seen by us: _____

(Previous / Present) Dentist: _____

_____

Last Visit Date: _____

Emergency Contac Name: _____

Relation: _____

Phone (Home / Cell): _____

2. INSURANCE COVERAGE

Dental Coverage: ☐Yes ☐No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's ID: _____

Insured's Name: _____

Relation: _____

Insured's Birthdate: _____

Insured's Employer: _____

3. MEDICAL HISTORY

Do you have a personal physician?: ☐Yes ☐No

Physician's Name: _____

Phone #: _____

Date of last visit: _____

Are you currently under the care of a physician?: ☐Yes ☐No

Please explain: _____

Your current physical health is: ☐Good ☐Fair ☐Poor

Are you taking any prescription / over-the -counter or herbal supplement drugs?: ☐Yes ☐No

Please list each one: _____

Have you ever taken Fosamax or any other bisphosphonates for osteoporosis?: ☐Yes ☐No

Have you been told that you snore or hold your breath or stop breathing while sleeping, or wake up gasping for breath?: ☐Yes ☐No

For Women: Are you using a prescribed method of birth control?: ☐Yes ☐No

Are you pregnant?: ☐Yes ☐No Week #: _____ weeks

Are you nursing?: ☐Yes ☐No

Have you ever had any of the following diseases or medical problems?

☐Yes ☐No Abnormal Bleeding
☐Yes ☐No Alcohol / Drug Abuse
☐Yes ☐No Anemia
☐Yes ☐No Arthritis
☐Yes ☐No Artifical Bones / Joints / Valves
☐Yes ☐No Asthma
☐Yes ☐No Blood Transfusion
☐Yes ☐No Cancer / Chemotherapy
☐Yes ☐No Colitis
☐Yes ☐No Congenital Heart Defect
☐Yes ☐No COVID-19
☐Yes ☐No Diabetes
☐Yes ☐No Difficulty Breathing
☐Yes ☐No Emphysema
☐Yes ☐No Epilepsy
☐Yes ☐No Fainting Spells

☐Yes ☐No Frequent Headaches
☐Yes ☐No Glaucoma
☐Yes ☐No Hay Fever
☐Yes ☐No Heart Attack
☐Yes ☐No Heart Murmur
☐Yes ☐No Heart Surgery
☐Yes ☐No Hemophilia
☐Yes ☐No Hepatitis
☐Yes ☐No Herpes / Fever Blisters
☐Yes ☐No HIV+ / AIDS
☐Yes ☐No Hospitalized for Any Reason
☐Yes ☐No Kidney Problems
☐Yes ☐No Liver Disease
☐Yes ☐No Low Blood Pressure
☐Yes ☐No Mitral Valve Prolapse
☐Yes ☐No Pacemaker
☐Yes ☐No Psychiatric Treatment
☐Yes ☐No Radiation Treatment
☐Yes ☐No Rheumatic /Scarlet Fever
☐Yes ☐No Seizures
☐Yes ☐No Shingles
☐Yes ☐No Sickle Cell Disease/ Traits
☐Yes ☐No Sinus Problems
☐Yes ☐No Stroke
☐Yes ☐No Thyroid Problems
☐Yes ☐No Tuberculosis
☐Yes ☐No Ulcers
☐Yes ☐No Venereal Disease

Please list any serious medical condition(s) you have ever had:

Are you allergic to any of the following?

☐Yes ☐No Aspirin
☐Yes ☐No Codeine
☐Yes ☐No Dental Anesthetics
☐Yes ☐No Erythromycin
☐Yes ☐No Jewelry
☐Yes ☐No Latex
☐Yes ☐No Metals
☐Yes ☐No Penicillin
☐Yes ☐No Siulfites
☐Yes ☐No Tetracycline

Please list any other drugs / materials that you are allergic to:

Why have you come to the dentist today?

Do you require antibiotics before dental treatment?: ☐Yes ☐No

Are you currently in pain?: ☐Yes ☐No

Do your gums ever bleed?: ☐Yes ☐No

Have you ever had a serious / difficult problem associated with any previous dental work?: ☐Yes ☐No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ/TMD): ☐Yes ☐No

Your current dental health is: ☐Good ☐Fair ☐Poor

Do you like your smile?: ☐Yes ☐No

Do you wish your teeth were straighter?: ☐Yes ☐No

Would you like whiter teeth?: ☐Yes ☐No

Do you grind or clench your teeth?: ☐Yes ☐No

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristles?: ☐Hard ☐Medium ☐Soft

Do you use an electric toothbrush?: ☐Yes ☐No

Do you smoke or use tobacco in any other form, or smoke any other substances?: ☐Yes ☐No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibvility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

signature date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

If you have dental insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

signature date

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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