Welcome! Thank You For Choosing Dr. Wei's Office!

PATIENT INFORMATION

Name (Last) ____________________
(First) _____________(Middle) _____
Birth-date ______m ____d _____yr
SSN _______-_____-_________
Address (street) ____________________
(City, State, Zip) __________GA 30___
Email ___________@__________
Home Phone (____) ____-________
Work Phone (____) ____-________
Cell. Phone (____) ____-________
Employer ____________________

Dental Insurance Info

Subscriber: yourself, spouse, parent.
Subcriber name________________________
SSN____-____-___

In Case of Emergency

Contact ____________________
Phone (____) ____-__________

How Do You Know US?

- ❑ Advertising Insurance Company
- ❑ Friend/Relative _______________
- ❑ Signage Yellow Pages
- ❑ Other ____________________

DENTAL HEALTH HISTORY

Are you having any discomfort? Yes No
Sensitive to hot, cold, sweets, chewing? Yes No
Do you have toothache at night? Yes No
Do you brush once a day, twice, or three times?
Floss daily, 1-2 times a week, rare, or none?
Bleeding gums or bad breath Yes No
Date of last cleaning _________yr ______m ___
Do you have jaw joint problem (click, pain)? Yes No
Do you grind your teeth at night or clench? Yes No
Easy gagging (when you brush)? Yes No
Are you nervous about dental treatment? Yes No
Do you smoke? Yes No
How much? _____Pack(s)/day; since the age ______
Please explain reason for your visit today
____
Name of Previous Dentist ____________________

Reason for Leaving _________________________

MEDICAL HEALTH HISTORY

Name of Physician ____________________
Phone (___) ___-________
Date of last visit to Physician ____________

Do you have or have you had, any of the following?

High blood pressure Yes No
Congestive heart failure Yes No
Do you take a medicine such as?
Plavix Coumadin Warfarin Osteoporosis
Heart murmur, Heart valve problem Yes No
Do you need to take an antibiotic before a dental procedure? Yes No
Easy bruising Yes No
Abnormal bleeding: you or relatives Yes No
Sinus problems Yes No
Asthma Yes No
Faint, Seizure or Epilepsy Yes No
Psychiatric or psychotic problem Yes No
Diabetes (Type I or II) Yes No
Hepatitis, Jaundice, or Liver Trouble Yes No
HIV-Positive/AIDS Yes No
Hospitalized in the past 5 years? Yes No
Are you allergic to any meds or Latex? Yes No
List meds you take or took in past year ____
____

Do you have any disease, problem, or condition not list above? Yes No
____

- For better oral health, visit www.xinweidds.com
- I agree to receive diagnosis and treatment
- I understand that the practice of dentistry is not an exact science and that NO GUARANTEES or assurances have been made to me concerning the outcome and/or result of any Procedures
- You have my permission to ask respective health care provider or agency to release information to you. I will notify the doctor of any change in my insurance, health or medication
- I know that payment is due when service is rendered and that I may be charged $35 per hour for appointment canceled less than 24 hours or for returned checks.
- I have read Financial Agreement and Notice of Privacy Practices (next 4 pages)
- Patients with insurance please choose:
- ❑ I authorize Dr. Wei to use my document to request payment from insurance, OR
- ❑ I would like to pay in full and obtain reimbursement from insurance myself

Patient/Guardian Signature_____________

Date _______/_______/202____

Doctor _________ Date ____/____/202_