Tony S. Suk, DDS, Inc.

North County Dental Center
1771-A Oceanside Blvd.
Oceanside, CA 92054
(760) 433-6081

PATIENT INFORMATION

Date: ______________________
Social Security #: _______-______-_________
Patient: ____
Address: ____
____
City State Zip
E-mail____
Sex: ف M ف F Age: _____ Birthdate: ____/____/_____

ف Single ف Married ف Widowed ف Separated ف Divorced

Occupation: ____
Employer: ____
Employer Address: ________________________________
____
Employer Phone: (____)______________________________

Spouse's Name: ___________________________________
Birthdate: ____/____/____ SS#: _______-_____-________
Occupation: ____
Spouse's Employer: _________________________________
Whom may we thank for referring you? _________________
____
Do you prefer morning or afternoon appts? ______________
Which days of the week do you prefer? _________________

DENTAL INSURANCE

Who is responsible for this account? ____________________
Relationship to Patient: ________________________________
Insurance Co: ____
Group #: ____

Is patient covered by additional insurances? ف Yes ف No
Subscriber's Name: ____________________________________
Birthdate: _____/_____/_____ SS#:_______-_____-_______
Relationship to Patient: ________________________________
Insurance Co. ____
Group #: ____

ASSIGNMENT AND RELEASE
I, the undersigned certify that (or my dependent) have insurance coverage with_____________________________________ and assign directly to Dr. Tony Suk and his associates, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party Signature

____
Relationship Date

PHONE NUMBERS

Home: (_____)________________ Work: (_____)________________Ext__________ Spouse's Work: (_____)__________________
Cell Phone: (_____)_________________ Other Number: (_____)__________________
Best time and place to reach you: ____

IN CASE OF AN EMERGENCY, CONTACT: (Specify someone who does not live in your household.)
Name: ____ Relationship: ________________________________
Home Phone: (_____)_________________ Work Phone: (_____)_________________ Cell Phone: (_____)_________________

DENTAL HISTORY

Reason for today's visit _____________
____
Former Dentist ____________________
City/State: ________________________
Date of last dental visit ______________
Date of last dental X-rays ____________
Date of last dental cleaning ___________

Please check "Yes" or "No" to indicate if you have had any of the following:

Bad breath ف Yes ف No
Bleeding gums ف Yes ف No
Blisters on lips or mouth ف Yes ف No
Burning sensation on tongue ف Yes ف No
Cigarette, pipe, or cigar smoking ف Yes ف No
Clicking or popping jaw ف Yes ف No
Dry mouth ف Yes ف No
Food collection between the teeth ف Yes ف No
Grinding teeth ف Yes ف No
Gums swollen or tender ف Yes ف No
Jaw pain or tiredness ف Yes ف No
Lip or cheek biting ف Yes ف No
Loose teeth or broken fillings ف Yes ف No
Mouth breathing ف Yes ف No
Mouth pain, brushing ف Yes ف No
Pain around ear ف Yes ف No
Periodontal treatment ف Yes ف No
Sensitivity to cold ف Yes ف No
Sensitivity to heat ف Yes ف No
Sensitivity to sweets ف Yes ف No
Sensitivity when biting ف Yes ف No
Sores or growths in your mouth ف Yes ف No
Number of times Brush__ /day, Floss__/day

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HEALTH HISTORY

Physician's Name ______________________________ Date of last visit ________________

Please check "Yes" or "No" to indicate if you have had any of the following:

Condition	Response	Condition	Response	Condition	Response
AIDS/HIV	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Bleeding abnormally, with		Hepatitis, Type ______	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor or growth on	
Cortisone Treatments	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	head or neck	☐ Yes ☐ No
Cough, persistent or		Nervous Problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
bloody	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Weight Loss,	
				Unexplained	☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "Fen-Phen?" ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date ________________ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Patient/Guardian's Signature: ______________________________ Date:________________

Doctor's Signature: ______________________________ Date: ________________

MEDICATIONS

List any medications you are currently taking and the conditions you are taking them for:

____

____

____

Pharmacy Name: ______________________

Phone #: ______________________

ALLERGIES

- ☐ No Known Drug Allergies
- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetics
- ☐ NSAIDS
- ☐ Penicillin
- ☐ Sulfa drugs
- ☐ Other___________ ________________

UPDATES (To be filled in at future appointments only)

Changes in health history: ______________________________

New medications: ______________________________

Patient's Signature: ______________________________ Date: ________________

Doctor's Signature: ______________________________ Date: ________________

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Changes in health history: ______________________________

New medications: ______________________________

Patient's Signature: ______________________________ Date: ________________

Doctor's Signature: ______________________________ Date: ________________