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Shieh Dental Healthcare

45A Pleasant St Malden, MA 02148

PERSONAL INFO

Part 1

Social Security # : _____ Date of Birth : _____/_____/_____
Month Day Year

Name _____
First Name Last Name Middle Initial

Address _____ **Apt.** ☐ _____ _____
(Street, Av,....?) City ZIP Code

Email: _____

Telephone: ( ) _____ ( )_____ ( )_____
Home Celullar Work

Sex _____ Height _____ Weight _____ Civil Status: Single ☐ Married ☐ Widow ☐ Divorced ☐

Friend or Close Relative: _____
Name Telephone

INSURANCE

Part 2

Employer's Name _____ Occupation _____

Dental Insurance Name: _____ Dental Group Number _____

Who provides you with this dental Ins Coverage? : Yourself ☐ Your husband or Wife ☐ Father or Mother ☐

Name and SS # of the Person _____ #_____
who provides you with this Insurance Name Social Security

MEDICAL HISTORY

Part 3

Name & telephone of your Primary Doctor_____

Date of last complete phisical:_____

Are you taken any medication? Yes ☐ No ☐ (If answer is yes) for what purpose ? _____

Are you allergic to: Penicillin ☐ Codeine ☐ Local Anesthesia ☐ Other medications ? _____

Have you have had any of the following?

Rheumatic Fever	Yes ☐	No ☐	Allergy	Yes ☐	No ☐	Hepatitis Jaundice or Liver Disease	Yes ☐	No ☐
High/Low Pressure	Yes ☐	No ☐	Sinusitis	Yes ☐	No ☐	Excessive urination and/or thirst	Yes ☐	No ☐
Ulcers	Yes ☐	No ☐	Asthma	Yes ☐	No ☐	Subject to prolonged bleeding	Yes ☐	No ☐
Tuberculosis	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐	Psychiatric Care	Yes ☐	No ☐
Diabetes.	Yes ☐	No ☐	Glaucoma	Yes ☐	No ☐	Heart murmur	Yes ☐	No ☐
Epilepsy	Yes ☐	No ☐	Nervous Problems	Yes ☐	No ☐	Heart Problems	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Kidney problems	Yes ☐	No ☐			
HIV Virus	Yes ☐	No ☐	Fainting spells	Yes ☐	No ☐	Describe: _____		

WOMEN ONLY: Are you pregnant (or suspect that you are) Yes ☐ No ☐ Are you taking BirthControl pills? Yes ☐ No ☐

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I authorize the doctor to release all the information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I agree that parents are responsible for all fees and services rendered for treatment of a child. I authorize the use of this signature on all insurance submissions.

Date _____/_____/_____ **Signature**:_____
Month Day Year Signature of adult required

Medical History Update		
Date:	Health Changes? Yes ☐ No ☐ If YES Explain	Signature:
Date:	Health Changes? Yes ☐ No ☐ If YES Explain	Signature:
Date:	Health Changes? Yes ☐ No ☐ If YES Explain	Signature: