Dental Wellness Centre
Hyo J. Lim, DMD
216 Mall Blvd. Suite 11
King of Prussia, PA 19406
610-265-4485

Patient Information Form

Name:____
Home Phone:_______________________________________
Home Address:_____________________________________
City:____
State:____________________
Employer:____
Work Phone:_______________________________________
Fax:____
Cell Phone:_______________________________________
Email:____
Social Security #_________________________________
Date of Birth:____________________________________
Occupation:_______________________________________
If Student School Name:___________________________

Do you have dental insurance coverage for self or through another family member?
YES I have Insurance:___________ NO I don't have insurance:____________

SELF FAMILY MEMBER

Insurance Company Name:____
Policy/Group #:____
Insured Spouse, Parent or other family member Name:_______________________
Insured Family Members Contact Phone Number:______________________________
Insured Family Members Employer:____
Insurance Holders Social Security #:______________________________________
Date of Birth:____
In case of emergency, please contact:_____________________________________
Phone:____
Who is financially responsible for this bill?:____________________________
I will be paying today by: CASH:___________CHECK:________CREDIT CARD:______

I understand and agree that, regard less of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I authorize this office to release any information necessary to expedite insurance claims. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or above information.

Signature:____ Date:________________________

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Health History

Please list the name(s) of the physician(s) and/or other healthcare provider(s) with whom you are currently working.

Physician:____
Nutritionist:____
Acupuncturist:____
Chiropractor:____
Homeopath:____
Other:____
Do you follow a vegetarian diet?:____
Are you currently on a prescribed diet? :____
Is your diet high in sugar/carbohydrate? :____
Do you drink coffee or other caffeinated beverages? :____
Do you smoke or use tobacco products? :____
Do you experience sore throats with no infection present? :____
Do infections take a long time to heal?:____

Dental History

Any face or jaw pain? :____
Any ear symptoms? Stuffiness, tinnitus or infections? :____
Any neck or shoulder discomfort? :____
Any low back or hip pain? :____
Any headaches? Where?____
Any chronic sinus problems? :____
Any history of choking? :____
Any history of passing out / fainting? :____
Unpleasant taste or bad breath? :____
Any other prior trauma to face or jaw? :____
Any use of alternative therapies? Chelation__Herbs__Homeopathy__Laser Magnets__**Other:**___________________
Any clicking or popping upon opening or closing your jaw? :____
Any deviation of your jaw as you open or close? :____
Any temperature sensitive teeth? :____
Any clenching or grinding or your teeth? Or have you been told you do?_____________________________________
Have you ever had a reaction to dental anesthetics? Explain:____
Have you ever had complications during or after dental care? Describe:______________________________________

Any additional information about your general health which we should know?____
____

Is there anything you can tell us that will make your visits here more comfortable?____

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Medical History: 1

- **Cancer:**
  Leukemia:___________________
  Hodgkin's Disease:____________
  Radiation Treatment:__________
  Chemotherapy:_______________
  Breast:______________________
  Other:______________________

- **Central Nervous System:**
  Bell's Palsy:_________________
  MS:________________________
  Epilepsy:___________________
  Convulsions:________________
  Fainting:___________________
  Lyme Disease:_______________
  Hepatitis/ Liver Disease:_______

- **Respiratory:**
  Asthma:____________________
  Emphysema:________________
  Bronchitis:__________________
  TB:________________________
  Allergies:___________________
  Sinus Problems:_____________

- **Blood Disorders:**
  Anemia:_____________________
  Hemophilia:_________________
  Blood Transfusion :___________
  High Blood Pressure:_________
  High Blood Pressure:_________
  Low Blood Pressure:__________

- **Other Allergies:**
  Latex:______________________
  Metals:_____________________
  Dental Anesthetics:___________
  Foods:______________________
  Other:______________________

- **Other Significant Illness:**
  Women's Health:_____________
  Currently Pregnant:___________
  Birth Control Pills:___________
  Using Hormone:______________
  If yes please
  specify:_____________________
  ____

- **Joint:**
  Painful Joints:_______________
  Arthritis/Rheumatoid
  Arthritis:____________________
  Systemic Lupus:_____________
  Erythematosis:_______________
  Artificial joint
  replacement:________________
  ____

- **Drug Allergies**
  Codeine:____________________
  Erythromycin:________________
  Penicillin:___________________
  Tetracycline:_________________
  Other:______________________

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Medical History: 2

- **Digestive:**
  Diverticulitis:_______________
  Ulcers:______________________
  Crohn's:_____________________
  Disease:_____________________
  Colitis:______________________
  Gastritis:____________________

- **Cardiac:**
  Heart Attack:________________
  Heart Surgery:_______________
  Heart Disease:_______________
  Abnormal EKG:_____________
  Heart Murmur:______________
  Mitral Valve Prolapse
  (MVP):_____________________
  Do you pre-med?:____________
  Angina:_____________________
  Rheumatic fever:_____________
  Stroke:_____________________

- **Fatigue:**
  Chronic Fatigue
  Syndrome:__________________
  Mononucleosis:______________

- **Respiratory:**
  Asthma:_____________________
  Emphysema:_________________
  Bronchitis:__________________
  TB:________________________
  Allergies:___________________
  Sinus Problems:_____________

- **Communicable Diseases:**
  VD (Syphilis, Gonorrhea)
  :___________________________
  AIDS, HIV, ARC:____________
  Herpes:_____________________
  Shingles:____________________
  Cold Sores:__________________

- **Respiratory:**
  Asthma:_____________________
  Emphysema:_________________
  Bronchitis:__________________
  TB:________________________
  Allergies:___________________
  Sinus Problems:_____________

- **Thyroid:**
  Hyperthyroid:_______________
  Hypothyroid:________________
  Grave's Disease:_____________

- **Reproductive/Urinary:**
  Hysterectomy:_______________
  Prostate Problems:___________
  Endometrioses:______________
  Urinary Infection:____________
  Kidney Disorder/Stones:_______

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Medical History: 3

- **Misc:**
  Lyme Disease:________________
  Hepatitis/ liver Disease:_______
  Jaundice:____________________
  Diabetes:____________________
  Family History Diabetes:______
- **Skin Conditions:**
  Psoriasis:____________________
  Eczema:_____________________
- **Additions:**
  Alcoholism:__________________
  Drugs:______________________
  Osteomyelitis:________________
  Ocular Problems:_____________
  Glaucoma:___________________
  Cataract:____________________
  Alzheimer's:_________________
  Schizophrenia:________________
  Meds:_______________________
  Anorexia Nervosa:____________
  Bulimia:_____________________

Have you had any illness or changes in health in the past year?
If yes please explain:
____
____

Surgeries/hospitalizations in the past 5 years?
If yes please explain:
____
____

Current Medications:____
____
____

Current Vitamins / Supplements/ Homeopathic / Herbs Other:
____
____
____

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Authorization to Release Confidential Patient Information

I,______________________________ , hereby request and authorize the requested copies of my dental records to be sent from the following office:

Dr.____

Please have all records sent to the following address at your earliest convenience:

Dental Wellness Centre
216 Mall Blvd. Suite 11
King of Prussia, P A 19406
p(61 0)265-4485
j(610)265-4486
dentalwellnessctr@yahoo.com

I expressly waive any provision of law forbidding your office from disclosing information acquired by examining or treating me. I further expressly release said entities from any and all liability arising from compliance with this request and disclosure of the requested information.

Signed: ____

Date: ______________________