Welcome to Our Dental Care: James C. Ma, D.D.S, Inc.
2017 E. Prosperity Ave
Tulare, CA. 93274
Ph#559-688-4111

Patient Information/*Informacion del Paciente*

Patient Name/*Nombre del Paciente* _____Birthdate/*Fecha de Nacimiento* _____

Social Security #/*Numero de Seguro Social*_____

Preferred Name/*Nombre Preferido*_____ Gender/*Genero* _____

Address/*Direccion*_____City/*Ciudad*_____Zip/*Codigo Postal*_____

Home Phone/*Telefono Particular* _____ (Cell/*Cellular*) _____ (Work/*Laboral*)_____

Email Address/*Correo Electronico*_____

I would like to receive and confirm appointments by text message and/or email: Yes or No

How did you hear about our office?/*Como se entero de nosotros*? _____

What is the purpose of your visit today?/*Explique el motive de la visita de hoy* _____

Emergency Contact Name/*Nombre del contacto de emergencia*_____Phone #/*Telefono* _____

Person Responsible for Payment/*Informacion del Responsable*

Name/*Nombre*_____ Relationship to Patient/*Relacion al Paciente*_____

Birthdate/*Fecha de Nacimiento* _____ Social Security #/*Numero de Seguro* _____

Phone Number/*Numero de Telefono* _____ Work #/*Telefono Laboral* _____

Address/*Direccion*_____City/*Ciudad*_____Zip/*Codigo Postal*_____

Insurance Information/*Informacion del Titular de Poliza*

Primary Insurance/*Aseguranza Primaria*

Name of Insured/*Nombre*_____Insured's Date of Birth/*Fecha de Nacimiento del Titular de Poliza* _____

Social Security #/*Numero de Seguro* _____

Insured's Address/*Direccion del Titular de Poliza* _____

Insurance Company Name/*Empresa de Seguro*_____

Policy Number/*Numero de Poliza*_____Group Number/*Numero del Grupo* _____

Insured's Employer Name/*Nombre del Empleador* _____

Address/*Direccion*_____

Secondary Insurance/*Aseguranza Secundaria*

Name of Insured/*Nombre*_____Insured's Date of Birth/*Fecha de Nacimiento del Titular de Poliza* _____

Social Security #/*Numero de Seguro* _____

Insured's Address/*Direccion del Titular de Poliza* _____

Insurance Company Name/*Empresa de Seguro*_____

Policy Number/*Numero de Poliza*_____Group Number/*Numero del Grupo* _____

Insured's Employer Name/*Nombre del Empleador* _____

Address/*Direccion*_____

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. It is agreed that payments will not be delayed or withheld due to any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without assuming responsibility for the collection thereof. It is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid by my insurance.

I understand that if my insurance company fails to pay a claim within 30 days of billing, the full amount of the claim becomes my responsibility to pay within the next 30 days. Interest charges will be applied to claims not paid promptly. **PLEASE NOTE**: Dr. James Ma cannot accept responsibility for collecting your insurance claim or negotiating settlement on a disputed claim--we bill your insurance company as a courtesy to you.

The patient's portion of the treatment charges is due and payable on the day of treatment, unless other written arrangements have been made in advance.

_____ _____

Patient Signature and/or Responsible Party/*Firma del Paciente o Tutor* **Date/*Fecha***

Medical History

Please Circle One

1. Are you having any discomfort at this time? ……..Yes No
2. Do you feel very nervous about having dental treatment? ..... Yes No
3. Have you ever had a bad experience at a dental office? ..... Yes No
4. Have you been a patient in the hospital during the past two years? ..... Yes No
5. Have you been under the care of a medical doctor during the past two years? ..... Yes No
6. Have you taken any medicine or drugs during the past two years? ..... Yes No
7. Have you ever had any excessive bleeding requiring special treatment? ..... Yes No
8. Are you allergic or do you react adversely to any of the following:

Aspirin Y/N **Tetracycline** Y/N **Latex** Y/N **Sulfa Drugs** Y/N **Metal** Y/N **Acrylic** Y/N
Local Anesthetics Y/N **Codeine** Y/N **Milk Protein** Y/N
Penicillin or any other antibiotics Y/N Please Specify: _____
Other: _____

9. Please check **YES** or **NO** next to **EACH ONE** of the following:

Y N	Y N	Y N	Y N
□ □ AIDS/HIV Positive	□ □ Convulsions	□ □ Heart Trouble/Disease	□ □ Pain in Jaw Joint
□ □Alzheimer's Disease	□ □ Diabetes	□ □ Hemophilia	□ □ Parkinson's Disease
□ □ Anaphylaxis	□ □ Drug/Alcohol Addict	□ □ Hepatitis A	□ □ Pins/Rods/Stints/Shunts
□ □ Anemia	□ □ Easily Winded	□ □ Hepatitis B or C	□ □ Psychiatric Care
□ □ Arthritis/Gout	□ □ Emphysema	□ □ Herpes	□ □ Radiation Treatments
□ □ Artificial Heart Valve	□ □ Endocarditis	□ □ High Blood Pressure	□ □ Rheumatic Fever
□ □ Artificial Joints	□ □ Epstein Barr	□ □ Hives or Rash	□ □ Rheumatism
□ □ Asthma	□ □ Epilepsy or Seizures	□ □ Hypoglycemia	□ □ Scarlett Fever
□ □ Blood Disease	□ □ Excessive Thirst	□ □ Human Papillomavirus (HPV)	□ □ Shingles
□ □ Blood Transfusion	□ □ Faint Spells/Dizziness	□ □ Irregular Heartbeat	□ □ Sickle Cell Disease
□ □ Breathing Problem	□ □ Frequent Cough	□ □ Jaw Joint Pain (TMJ)	□ □ Sinus Problem
□ □ Bruise Easily	□ □ Frequent Headaches	□ □ Kidney Problems	□ □ Sleep Apnea
□ □ Cancer	□ □ Glaucoma	□ □ Leukemia	□ □ Stomach/Intestinal Disease
□ □ Chemotherapy	□ □ Hay Fever	□ □ Liver Disease	□ □ Stroke
□ □ Chest Pains	□ □ Heart Attack/Failure	□ □ Low Blood Pressure	□ □ Thyroid Disease
□ □ Chronic Fatigue	□ □ Heart Murmur	□ □ Lung Disease	□ □ Tuberculosis
□ □ Cold Sores/Fever Blisters	□ □ Heart Pacemaker	□ □ Mitral Valve Prolapse	□ □ Tumors or Growths
□ □ Congenital Heart Disorder	□ □ Heart Surgery	□ □ Osteoporosis	□ □ Ulcers
			□ □ Yellow jaundice

Please Circle One

10. When you walk upstairs or take a walk, do you ever have to stop due to pain in your chest, shortness of breath or extreme fatigue?.....Yes No
11. Do your ankles swell during the day? ..... Yes No
12. Do you use more than two pillows to sleep in order to breathe better? ..... Yes No
13. Have you changed more than ten pounds in the past year? .....Lost_____ Gained_____..... Yes No
14. Do you ever wake up from sleep short of breath? ..... Yes No
15. Do you currently or have you ever used tobacco? .... Cigarettes_____ Chew_____ Cigars___ How long_____ Yes No
16. Are you on a special diet/taking any diet pills (Phen-Fen, etc.) ..... Yes No
17. Has your medical doctor ever said you have cancer or a tumor? ..... Yes No
18. Would you like to speak with someone confidentially to receive help/information about domestic violence? ..... Yes No
19. Do you have any disease, condition or problem not listed? ..... Yes No
20. WOMEN: Are you pregnant now? ..... Yes No
    Are you currently taking birth control pills? ..... Yes No
21. CURRENT MEDICATIONS: _____

I understand that the information I have provided on this form is essential to determining my dental health needs and the provision of dental treatment. I understand that if any changes occur in my health or my medicines, I will inform Dr. Ma at my next appointment without fail. I have read and understood each question and have answered all of them truthfully and to the best of my ability.

Patient (and/or Responsible Party/Guardian) Signature Date