



Kyle K Leong DDS LLC

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PATIENT INFORMATION

Date _____
SS/HIC/Patient ID # _____
Patient Name _____
Last name _____
First Name _____ Middle Int _____
Address _____
Email _____
City _____
State _____ Zip _____
Sex M F Age _____
Birthdate _____
 Married Widowed Single Minor
 Seperated Divorced Partnered
Patient Employer/School _____
Occupation _____
Employer Address _____
Employer Phone (____) _____
Spouse's Name _____
Birthdate _____
SS# _____
Spouse's Employer _____
Whom may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for Acct? _____
Relationship to pt _____
Insurance Co. _____
Group# _____
Dual insurance? Yes No
Subscriber's Name _____
Birthdate _____ SS# _____
Relationship to patient _____
2nd Insurance Co _____
2nd Ins Group # _____

Assignment and Release

I certify that I, and/ or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of insurance company _____
Dr. _____ 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 authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance companies and their agents pose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Rep _____
Print Name _____
Date _____ Relationship to pt _____

PHONE NUMBERS

Home (____) _____ Work (____) _____ Ext ____ Cell Phone (____) _____
Spouse's Work (____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____
Home Phone (____) _____ Work Phone (____) _____

DENTAL HISTORY

Reason for today's visit _____	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth Breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Chew on 1 side only <input type="checkbox"/> Yes <input type="checkbox"/> No	Blisters on lips <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Ortho Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Clicking or popping of jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Dry Mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to Cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last X-rays _____	Food Collecting btwn teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Foreign Objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes or "no" to indicate if you have had any of the following:	Grinding Teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
	Gums Swollen or Tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad Breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush (day) _____
Bleeding Gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or check biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss (day) _____

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "Fen-phen?" These include combinations of Lonimin, Adipex, Fastin (Brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine) Yes No

Place a mark on "yes" or "No" to indicate if you have had any of the following:

- | | | | | | |
|--------------------------|--|-----------------------|--|--------------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmurs | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Excessive bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | High blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart lesions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor on head or neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, chronic/ bloody | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Women:

Are you taking birth control pills: Yes No

Are you pregnant? Yes No Due date _____ Are you nursing _____

MEDICATIONS

List any medications and reasons for taking:

ALLERGIES

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthesia |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Latex | _____ |

UPDATES(To be filled in at future appointments)

Has there been any changes in your health since your last dental appt? Yes No

For what conditions? _____

Are you taking any new medications ? _____ If so what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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Has there been any changes in your health since your last dental appt? Yes No

For what conditions? _____

Are you taking any new medications ? _____ If so what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____