# Lowry Y Wong, DDS

**Park Place**

**4647 Long Beach Blvd, Suite A-1**

**Long Beach, Ca 90805-6977**

**562-426-6594**

lywongdds@gmail.com

Date ______________________

Patient's Name Last First Middle

Date of Birth Social Security Number

## 1. Dental History

Reason for today's visit: ______________________

Former Dentist's Name and Phone Number ______________________

Date of last dental visit ______________________

Tell us about your current dental problems ______________________

Any problems associated with previous dental treatment? If yes, please explain ______________________

| | | | | | |
|---|---|---|---|---|---|
| Does dental treatment make you nervous? | Y ☐ | N ☐ | Are your teeth sensitive to cold, hot or sweets? | Y ☐ | N ☐ |
| Do your gums bleed when you brush/floss? | Y ☐ | N ☐ | I would like my teeth whiter | Y ☐ | N ☐ |
| I would like my teeth straighter | Y ☐ | N ☐ | I have chips on my teeth I want fixed | Y ☐ | N ☐ |

## 2. Medical History

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of Physician: ______________________ Phone Number of Physician: ______________________

Please list all prescription and non-prescription medication within the last 6 months:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________

**Do you have or ever had any of the following?**

| | | | | | |
|---|---|---|---|---|---|
| AIDS/HIV POSITIVE | Y | N | HEPATITIS A,B, OR C | Y | N |
| ANEMIA | Y | N | HYPERTENSION | Y | N |
| ARTHRITIS | Y | N | KIDNEY DISEASE | Y | N |
| ARTIFICIAL HEART/VALVE | Y | N | LIVER DISEASE | Y | N |
| ASTHMA | Y | N | LUPUS | Y | N |
| AUTISM | Y | N | MENTAL HEALTH CONCERNS | Y | N |
| AUTOIMMUNE DISEASE | Y | N | MITRAL VALVE PROLAPSE | Y | N |
| BLOOD/CLOTTING DISORDER | Y | N | MOOD OR STRESS DISORDER | Y | N |
| BRUISE EASILY | Y | N | MULTIPLE SCLEROSIS | Y | N |
| CANCER | Y | N | ORGAN TRANSPLANT | Y | N |
| DELAYED HEALING | Y | N | PACEMAKER | Y | N |
| DIABETES | Y | N | ROUTINE ANTIBIOTICS BEFORE DENTAL VISIT | Y | N |
| EATING DISORDER | Y | N | RHEUMATIC FEVER | Y | N |
| DRUG/ALCOHOL DEPENDENCY | Y | N | STROKE | Y | N |
| EPILEPSY/SEIZURES | Y | N | THYROID DISEASE | Y | N |
| GLAUCOMA | Y | N | TAKEN IV or ORAL BisPhosphonates | Y | N |
| FAINTING | Y | N | TUBERCULOSIS | Y | N |
| HEART DISEASE/ATTACK | Y | N | ULCERS/ ULCERATIVE COLITIS | Y | N |
| HEART DEFECT/MURMUR | Y | N | RECENT ER VISIT / HOSPITALIZATION | Y | N |
| HEART PROBLEMS | Y | N | SMOKE | Y | N |

**Do you have any medical condition not listed above, if so, please explain:** ____________________

____________________________________________

Have you been allergic to or had a bad reaction to:

| | | | | | |
|---|---|---|---|---|---|
| Amoxicillin/Penicillin | Y | N | Codeine | Y | N |
| Aspirin/Advil/Ibuprofen | Y | N | Dental anesthetic | Y | N |
| Cephalosporin | Y | N | Erythromycin | Y | N |
| Clindamycin | Y | N | Latex | Y | N |

Any other allergies to medications? ____________________

**WOMEN: Are you pregnant? Y N Month** ____________________

*I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health and I will not hold my Dentist or any members of his Dental team responsible for errors or emissions that I have made in completion of this form. It is my responsibility to notify my Dentist of any changes in the above medical status in the future.*

Patient or Responsible Party Signature ____________________ Date __________

Doctor's Signature and Date ____________________