

Robert P. Choi, DDS
Family & Cosmetic Dentistry
1919 O'Farrell St Suite 2
San Mateo, CA 94403

Welcome to our practice!

First Name		Middle Initial	Last Name	
Responsible Party, if patient is a minor		Relationship to patient		Birthdate
Social Security No.		Email Address		
Gender	☐ Male ☐ Female	Marital Status	☐ Minor ☐ Single ☐ Married/Partnered ☐ Widowed ☐ Divorced/Separated	
Street Address		City	State	Zip Code
Home Phone		Cell Phone		
Business Phone		Ext	Employer	Occupation
Business Street Address		City	State	Zip Code



How did you hear about us?

☐ Referred By Relationship

☐ Yelp ☐ Google ☐ Opencare ☐ Other



In case of an emergency,
who should we contact?

Contact Name

Phone Relationship

Insurance

Insured Member		Relationship to Patient
Employer	Telephone	Birthdate
Insurance Company	Group No.	Social Security No./ Subscriber ID No.

Secondary

Insured Member		Relationship to Patient
Employer	Telephone	Birthdate
Insurance Company	Group No.	Social Security No./ Subscriber ID No.

Dental History

Reason for today's visit

Former Dentist

City State

Date of last visit Date of last x-rays

How often do you floss? How often do you brush?

- ☐ Y ☐ N Bleeding Gums
☐ Y ☐ N Burning Sensation on Tongue
☐ Y ☐ N Chewing on one side of Mouth
☐ Y ☐ N Fingernail Biting
☐ Y ☐ N Food Collection between Teeth
☐ Y ☐ N Frequent Headaches
☐ Y ☐ N Grinding Teeth
☐ Y ☐ N Gums Swollen or Tender
☐ Y ☐ N Jaw Difficulty, Clicking and/or Pain
☐ Y ☐ N Jaw, Head, or Neck Injuries

- ☐ Y ☐ N Loose Teeth or Broken Fillings
☐ Y ☐ N Orthodontic Treatment
☐ Y ☐ N Pain Around Ear
☐ Y ☐ N Periodontal Treatment
☐ Y ☐ N Sensitivity to Cold
☐ Y ☐ N Sensitivity to Heat
☐ Y ☐ N Sensitivity to Sweets
☐ Y ☐ N Sensitivity when Biting
☐ Y ☐ N Sores or Growths in Your Mouth
☐ Y ☐ N Tooth Pain

Medical History

Physician

Hospital Affiliation

City State Last Visit

- ☐ Y ☐ N Currently under medical treatment
☐ Y ☐ N Smoke, frequency: _____
☐ Y ☐ N Alcohol Use
☐ Y ☐ N Recreational drug use
☐ Y ☐ N Serious illnesses or operations: _____

- ☐ Y ☐ N AIDS
☐ Y ☐ N Anemia
☐ Y ☐ N Arthritis, Rheumatism
☐ Y ☐ N Artificial Heart Valves
☐ Y ☐ N Artificial Joints
☐ Y ☐ N Asthma
☐ Y ☐ N Back Problems
☐ Y ☐ N Bleeding abnormally, with extractions or surgery
☐ Y ☐ N Blood Disease
☐ Y ☐ N Cancer
☐ Y ☐ N Chemical Dependency
☐ Y ☐ N Chemotherapy
☐ Y ☐ N Chronic Fatigue Syndrome
☐ Y ☐ N Circulatory Problems
☐ Y ☐ N Congenital Heart Lesions
☐ Y ☐ N Cortisone Treatments
☐ Y ☐ N Cough (persistent or bloody)
☐ Y ☐ N Diabetes
☐ Y ☐ N Emphysema
☐ Y ☐ N Epilepsy
☐ Y ☐ N Fainting or Dizziness
☐ Y ☐ N Glaucoma
☐ Y ☐ N Headaches
☐ Y ☐ N Heart Murmur
☐ Y ☐ N Heart Problems
☐ Y ☐ N Hepatitis, Type _____
☐ Y ☐ N Herpes, Type _____
☐ Y ☐ N High Blood Pressure
☐ Y ☐ N HIV Positive
☐ Y ☐ N Jaundice
☐ Y ☐ N Jaw Pain
☐ Y ☐ N Kidney Disease
☐ Y ☐ N Latex Sensitivity
☐ Y ☐ N Liver Disease

- ☐ Y ☐ N Low Blood Pressure
☐ Y ☐ N Mitral Valve Prolapse
☐ Y ☐ N Nervous Problems
☐ Y ☐ N Pacemaker
☐ Y ☐ N Psychiatric Care
☐ Y ☐ N Radiation Treatment
☐ Y ☐ N Respiratory Disease
☐ Y ☐ N Rheumatic Fever
☐ Y ☐ N Scarlet Fever
☐ Y ☐ N Shortness of Breath
☐ Y ☐ N Sinus Trouble
☐ Y ☐ N Skin Rash
☐ Y ☐ N Stroke, Date _____
☐ Y ☐ N Swelling of Feet/Ankles
☐ Y ☐ N Swollen Neck Glands
☐ Y ☐ N Thyroid Problems
☐ Y ☐ N Tonsillitis
☐ Y ☐ N Tuberculosis
☐ Y ☐ N Tumor or Growth on Head/ Neck
☐ Y ☐ N Ulcer
☐ Y ☐ N Venereal Disease
☐ Other _____

Medications

Pharmacy Telephone

Allergies

- ☐ Y ☐ N Penicillin/Antibiotics
☐ Y ☐ N Sulfa Drugs
☐ Y ☐ N Barbiturates
☐ Y ☐ N Sedatives
☐ Y ☐ N Iodine
☐ Y ☐ N Latex
☐ Y ☐ N Metals
☐ Other _____

Women Only

- ☐ Y ☐ N Pregnant, Due Date: _____
☐ Y ☐ N Nursing
☐ Y ☐ N Using Birth-Control Pills

Office Use Only

Doctor Date

Assignment and Release

I hereby authorize payment directly to Robert P. Choi, DDS for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above practice and/ or any provider or supplier of services in this office to release this information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party

Date