Patient Registration
Sheng Ji, DDS, MD, Inc.

Dr. Terrence Robbins, DMD
Dr. Sheng Ji, DDS, MD

Patient Information

Name: _____ _____ M F
Last Name First Name MI Sex

Date of Birth: _____/_____/_____ Age: _____ SS# _____

Address: _____
Street City State Zip

Phone #'s: Home (_____)_____ Work (_____)_____ Cell (_____)_____

Dentist Name: _____ Phone Number: _____ Date of Last Visit: _____

Email Address: _____ Employer: _____

Emergency Contact: _____ Phone # (_____)_____ Relationship _____

Whom May We Thank for Referring You _____

Accident or Injury Related Condition? Y / N Date of Injury: _____ Auto Injury? Y / N

Work Related Condition: Y / N If yes, date: _____ Description: _____

Responsible Party: The person who is responsible for this account

Name: _____ _____
Last Name First Name Relationship to Patient

Address: _____
Street City State Zip

Phone #'s: Home (_____)_____ Work (_____)_____ Cell (_____)_____

SS# _____ Employer: _____

Dental Insurance:

Subscriber Name: _____ _____/_____/_____
Last Name First Name Date of Birth

Subscriber Address: _____
Street City State Zip

Patient Relationship to Subscriber: □ Spouse □ Child □ Other _____

SSN #:_____ Insurance ID #:_____ Policy/Group #_____

Insurance Company Name: _____

Employer: _____

Patient Registration
Sheng Ji, DDS, MD, Inc.

Dr. Terrence Robbins, DMD
Dr. Sheng Ji, DDS, MD

Patient Name: _____ Date of Birth _____/_____/_____

Medical Insurance:

Subscriber Name: _____ _____
Last Name First Name Date of Birth

Subscriber Address: _____
Street City State Zip

Patient Relationship to Subscriber: □ Spouse □ Child □ Other _____

SSN #:_____ Insurance ID #:_____ Policy/Group #_____

Insurance Company Name: _____

Employer: _____

Insurance Agreement

Patients with dental insurance understand that all services are charged directly to the patient and that he or she is ultimately responsible for payment of all services. It is your responsibility to notify us of any change in your insurance coverage or benefits to insure timely submission of claims. Our office will gladly prepare the insurance forms to assist in obtaining payment from insurance companies and will accept payments directly to our office. Insurance benefit calculations provided by our office are done as a courtesy and are not a guarantee of coverage. Denied services, payments that differ from the estimated payment or claims not paid within 60 days of submission are your responsibility. If a more definitive estimate of your insurance benefits is desired please request a submission for Predetermination of Benefits before treatment begins.

Financial Policy

Payment for services provided by Dr. Ji and Dr. Robbins is due the day services are rendered, unless prior arrangements have been made. If you are interested in learning more about our payment options please ask our expert staff before treatment begins. All balances not paid as agreed are subject to 1 ½ % per month (annual rate 18%) until paid in full.

When applicable, your fees are based on an assumed anesthesia time. You may owe fee for additional anesthesia time if surgery runs longer than anticipated.

_____
Signature of Patient (over 18 years of age) or Legal Guardian (if under 18 years of age) Date

Health History
Sheng Ji, D.D.S., M.D., Inc.

Patient Name: _____

Date of Birth: _____

Dental Information

Please mark (X) Yes, No or DK (don't know)

	Yes	No	DK
Are you currently experiencing dental pain?	□	□	□
Do you have clicking, popping or discomfort in the jaw?	□	□	□
Do you have or have you ever had problems opening your mouth wide?	□	□	□
Have you ever had a serious injury to your face, jaw or neck?	□	□	□
Have you ever had any problems associated with previous dental treatment?	□	□	□
Do you wear removable dentures or partials?	□	□	□

Medical Information

Height: _____ Weight: _____

Physicians Name: _____

Please mark (X) Yes, No or DK (don't know)

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years? ……..	□	□	□

If yes, please list all: _____

_____

_____

_____

_____

	Yes	No	DK
Are you taking any of the following drugs:			
Antibiotics or sulfa drugs ……..	□	□	□
Blood thinners (Coumadin, Warfarin, Plavix , Aspirin, Pradaxa, Xarelto or other) …….	□	□	□
High blood pressure medication …….	□	□	□
Cortisone/Steroids ……	□	□	□
Tranquilizers /Barbiturates ……	□	□	□
Insulin or other diabetes medication ……..	□	□	□
Nitroglycerine ……	□	□	□
Digitalis or other heart medications ……...	□	□	□
Are you taking any other prescription, over-the-counter or herbal medications? …….	□	□	□

If yes, please list all, including vitamins, natural or herbal preparations, diet supplements. _____

_____

_____

_____

_____

	Yes	No	DK
Do you now or have you ever used marijuana ……..……	□	□	□

	Yes	No	DK
Do you now or have you ever used street or recreational drugs ..…….……..	□	□	□

If yes, please list all: _____

_____

_____

_____

	Yes	No	DK
Do you drink alcohol? ……	□	□	□
How much in a typical week? _____			
Do you smoke? ……..	□	□	□
How much? _____			
Are you wearing any facial or oral piercings? …	□	□	□
Do you wear contact lenses? ……...	□	□	□

	Yes	No	DK
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelivia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? ……..	□	□	□
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGeva) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer. ……...	□	□	□

	Yes	No	DK
Joint Replacement: Have you had an Orthopedic total joint replacement (hip, knee elbow, finger shoulder)? ……..	□	□	□
If yes: Date: _____			

Women Only:	Yes	No	DK
Are you pregnant? ……	□	□	□
If yes, number of weeks _____			
Are you Nursing? ……..	□	□	□
Are you taking birth control pills? ……..	□	□	□

Patient Name: _____

Allergies

Are you allergic to or have you had a reaction to:

	Yes	No	DK
Local Anesthetic	□	□	□
Aspirin	□	□	□
Penicillin/antibiotics	□	□	□
Sulfa drugs	□	□	□
Barbiturates, sedatives or sleeping pills	□	□	□
Codeine or other narcotics	□	□	□
Latex (rubber)	□	□	□
Eggs	□	□	□
Soy	□	□	□
Iodine	□	□	□

Cardiac Diseases or Problems	Yes	No	DK
Artificial (prosthetic) heart valve	□	□	□
Previous infective endocarditis	□	□	□
Damaged valves or transplanted heart	□	□	□
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	□	□	□
Repaired (completely) in last 6 months	□	□	□
Repaired CHD with residual defects	□	□	□
Cardiovascular disease	□	□	□
Angina	□	□	□
Arteriosclerosis	□	□	□
Congestive heart failure	□	□	□
Damaged heart valves	□	□	□
Heart attack	□	□	□
Heart murmur	□	□	□
Low blood pressure	□	□	□
High blood pressure	□	□	□
Other congenital heart defects	□	□	□
Mitral valve prolapse	□	□	□
Pacemaker	□	□	□
Chest Pain upon exertion	□	□	□
Rheumatic fever	□	□	□
Rheumatic heart disease	□	□	□
Thrombophlebitis or Blood Clot	□	□	□
Stroke	□	□	□

Diseases or Problems	Yes	No	DK
Abnormal Bleeding	□	□	□
Blood Transfusion	□	□	□
If yes, date: _____			
Hemophilia	□	□	□
Anemia	□	□	□
Aids or HIV infection	□	□	□
Arthritis	□	□	□
Autoimmune disease	□	□	□
Rheumatoid arthritis	□	□	□
Systemic lupus erythematosus	□	□	□
Asthma	□	□	□
Bronchitis	□	□	□

	Yes	No	DK
Emphysema	□	□	□
Sinus trouble	□	□	□
Tuberculosis	□	□	□
Cancer/ Leukemia	□	□	□
Radiation Treatment	□	□	□
Diabetes I or II	□	□	□
Eating Disorder	□	□	□
Malnutrition	□	□	□
Gastrointestinal disease	□	□	□
Acid Reflux/persistent heartburn	□	□	□
Ulcers	□	□	□
Thyroid problems	□	□	□
Glaucoma	□	□	□
Hepatitis, jaundice or live disease	□	□	□
Epilepsy	□	□	□
Fainting spells or seizures	□	□	□
Neurological disorder	□	□	□
If yes, specify _____			
Sleep Disorder	□	□	□
Mental disorder	□	□	□
If yes, specify _____			
Recurrent infections	□	□	□
Type of infection: _____			
Kidney Problems	□	□	□
Night sweats	□	□	□
Osteoporosis	□	□	□
Persistent swollen glands in neck	□	□	□
Severe Headaches/migraines	□	□	□
Severe or rapid weight loss	□	□	□
Sexually transmitted disease	□	□	□
Excessive urination	□	□	□

Do you have any disease, condition, or problems not listed above that you think I should know about? □ □ □

Please explain: _____

_____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____

Signature of Patient/Legal Guardian Date

_____

Signature of Doctor Date