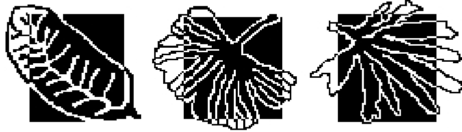


Jerry Hong, DDS
Kari Ann Hong, DDS

Get Acquainted Questionnaire

In order for us to better serve you, please fill in the following information completely:

Patient name: ____ Date of birth: _____/_____/_____ M or F

Home Phone: __________________ Cell Phone:_______________________ Work Phone:_____________________

Email address: ____________________________ Best way to contact you:___________________________________

Social Security #: _____________________ Driver's License #: ______________________

Residence Address: _____________________________ City: __________________________ Zip: __________________

Occupation: _______________________ Employer: __________________________________ Phone: ________________

School (Students only): ____________________________

Former Dentist: ____ Date of last dental visit: _____/_____/_____

How did you learn about us? ____

Person to contact in case of emergency: _____________________________________ Phone: ________________________

** Please compete the following ONLY if patient is covered by Dental Insurance:

Name of person carrying the Insurance: ___________________________ Date of birth: _____/_____/_____
Social Security #: _______________________
Name of Insurance Co. ____ Group Plan #: ___________________________
Name of Employer____ Work Phone Number:_____________________
Authorize to Assign Benefits. Patient Signature: ____

Is the patient covered by another Insurance Plan? Yes NO
Name of person carrying the Insurance: ___________________________ Date of birth: _____/_____/_____
Social Security #: _______________________
Name of Insurance Co. ____ Group Plan #: ___________________________
Name of Employer____ Work Phone Number:_____________________
Authorize to Assign Benefits. Patient Signature: ____

For your benefit, a thorough examination, frequently including dental X-rays and diagnostic models of your mouth, is necessary before and intelligent and efficient analysis of your dental problems can be made. The assistants at the front desk can advise you of the fee for these services. After thorough diagnosis, your dental problems can be intelligently discussed; treatment can be planned, and your investment in this plan understood and arranged. It is a pleasure to survey your dental needs and discuss these problems with you. Should you choose to place the care of your dental health with us, please be assured that the most thorough, conscientious service will be dedicated to this trust. All facilities and personnel of this office are expressly here to serve you and your health.

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on the Health History form, to administer such anesthetic, analgesics, sedatives, x-rays, and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

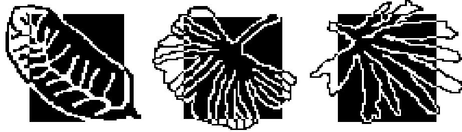
TERMS AND CONDITIONS: A service charge of 1% per month (12% annum) will be charged on the unpaid balance on all accounts exceeding 60 days.

I hereby authorize the release of any information, including the diagnosis and the records of any treatment rendered, to my insurance company.

Signature: ____ Date: _____/_____/_____

Authorization must be signed by the patient, or by nearest relative in the case of a minor when the patient is physically or mentally incompetent.
Relationship to the patient: ____

1000 Newbury Road, Suite 190 ·Thousand Oaks, CA 91320 ·(805) 480-9820 phone
www.dentist4smiles.com ·(805) 480-9735 fax



Jerry Hong, DDS
Kari Ann Hong, DDS

Your Health History

I. Check appropriate answer; leave blank if you do not understand the question.

Yes No
____ ____ Is your general health good?
____ ____ Has there been a change in your health within the last year?
____ ____ Have you been hospitalized or had a serious illness in the last three years?
____ ____ Are you being treated by a physician now? Please explain: ____
If yes to (above), list name of medical doctor:____
____ ____ Have you had any problems with prior dental treatment?
____ ____ Are you in pain now?

II. Have you experienced:

Yes No
____ ____ Chest pain (angina)?
____ ____ Shortness of breath?
____ ____ Recent weight loss, fever, night sweats?
____ ____ Persistent cough, coughing up blood?
____ ____ Bleeding problems, bruising easily?
____ ____ Sinus problems?
____ ____ Difficulty swallowing?
____ ____ Diarrhea, constipation, blood in stools?
____ ____ Frequent vomiting, nausea?
____ ____ Difficulty urinating, blood in urine?
____ ____ Joint pain, stiffness?

Yes No
____ ____ Dizziness?
____ ____ Ringing in the ears?
____ ____ Headaches?
____ ____ Fainting spells?
____ ____ Blurred vision?
____ ____ Seizures?
____ ____ Excessive thirst?
____ ____ Frequent urination?
____ ____ Dry mouth?
____ ____ Jaundice?

III. Do you or have you had:

Yes No
____ ____ Heart disease?
____ ____ Heart attack, heart disease?
____ ____ Heart murmurs?
____ ____ Rheumatic fever?
____ ____ Stroke, hardening of arteries?
____ ____ High blood pressure?
____ ____ TB, emphysema, asthma, other lung disease?
____ ____ Hepatitis or liver disease?
____ ____ Stomach problems, ulcers?
____ ____ Allergies to drugs, food medications?
____ ____ Diabetes?

Yes No
____ ____ AIDS or ARC
____ ____ Tumors, cancer?
____ ____ Arthritis, rheumatism?
____ ____ Eye disease, glaucoma?
____ ____ Skin diseases?
____ ____ Anemia?
____ ____ VD (syphilis or gonorrhea)?
____ ____ Herpes?
____ ____ Kidney, bladder disease?
____ ____ Thyroid, adrenal disease?

IV. Do you or have you had:

Yes No
____ ____ Psychiatric care?
____ ____ Radiation treatments?
____ ____ Chemotherapy?
____ ____ Prosthetic heart valve?
____ ____ Hospitalization?
____ ____ Surgeries?
___ _____ Pacemaker?
____ ____ Contact lenses?

V. Are you taking:

Yes No
____ ____ Recreational drugs?
____ ____ Drugs, medication (including aspirin)?
Please list: ___________________________________
____ ____ Tobacco in any form?
____ ____ Alcohol?
____ ____ Phen-Phen or diet pills?

IV. Women Only
____ ____ Are/could you be pregnant or nursing?
____ ____ Taking birth control pills?

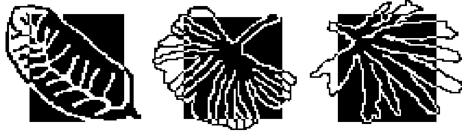
VI. Do you or have you had:

Yes No
____ ____ Sensitivity in the mouth to heat, cold, sweet or pressure?
____ ____ Growths or sore spots in or around your mouth?
____ ____ Habitually clench or grind your teeth during day or night?
____ ____ Prolonged bleeding following extractions in the past?
____ ____ Trench mouth or any other gum conditions?
____ ____ A dislike about the appearance of your teeth?
____ ____ Sleep apnea, wake up tired or sick with a headache?

Yes No
____ ____ Trouble chewing?
____ ____ Difficult tooth extractions in the past?
____ ____ Food catch between your teeth?
____ ____ Bleeding gums?
____ ____ Bad breath?
____ ____ A bad dental experience?
____ ____ A snoring problem?

VIII. All patients:
How may we help you this visit?____
To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changed in my health and/or medication.
Patient's signature: ____ Date: _____/_____/_____
Printed patient's name:____
Dentist's signature: ____ Date: _____/_____/_____

1000 Newbury Road, Suite 190 ·Thousand Oaks, CA 91320 ·(805) 480-9820 phone
www.dentist4smiles.com ·(805) 480-9735 fax



Jerry Hong, DDS
Kari Ann Hong, DDS

DENTAL MATERIAL FACT SHEET

Dental Material Fact Sheet form for Jerry Hong, DDS and Kari Ann Hong, DDS
I have received a copy of the Dental Material Fact Sheet as required by law.

Signature:

Date:

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt of Notice of Privacy Practices for Jerry Hong, DDS and Kari Ann Hong, DDS
I have received a copy of this office's Notice of Privacy Practices.

Signature:

Date:

1000 Newbury Road, Suite 190 ·Thousand Oaks, CA 91320 ·(805) 480-9820 phone
www.dentist4smiles.com ·(805) 480-9735 fax