H. Peter Ku, D.D.S., PA

Laura Jo Klein, D.D.S./Darrell Pruitt, D.D.S.
Family and Cosmetic Dentistry

PATIENT HISTORY

Patient Name: _____ **SSN** _____

DL# _____ **State** ____ **Birthdate** _____

Address _____ **Preferred Method of Contact – circle one**
Home phone Cell Phone Email

City/State/Zip _____

Home Phone _____
Cell phone _____
Email _____

Patient: ☐ Adult ☐ Child

☐ Male ☐ Female

H. Peter Ku, DDS, PA may send email messages such as appointment reminders.

☐ Spouse's ☐ Parent's
Name _____ SSN _____ DOB _____

Address (if different from patient) _____ Home Phone _____
_____

Employer and Insurance Information
☐ Patient ☐ Parent
Employed by _____ Work Phone _____
Business Address _____
_____

Spouse Employed by _____ Work Phone _____
Business Address _____
_____

Insurance Company _____

Coverage: ( ) Self, ( ) Self & Dependents or ( ) Family

Dental Insurance Coverage is through:
Self SSN _____
Spouse SSN _____
Spouse DOB _____

Medical History Information
It is important that your dentist know about your medical history. Many things have a direct bearing on your dental health. Your answers are for our records only and will be considered confidential. Please answer the following by circling either Y or N on **each** selection:

Anemia/Blood Disease	Y N	Glaucoma	Y N	Neck/Head Pain	Y N	**Allergies**	
Arthritis	Y N	Heart Trouble	Y N	Pregnant**(currently)**	Y N	Aspirin	Y N
Asthma/Hay Fever	Y N	Pace Maker	Y N	Rheu Fever/Murmur	Y N	Codeine	Y N
Blood Pressure/High	Y N	Hepatitis/Liver Dis .	Y N	Stroke	Y N	Local Anest.	Y N
Blood Pressure/Low	Y N	Herpes Virus	Y N	TB/Lung Disease	Y N	Penicillin	Y N
Cancer/Tx/X-Ray	Y N	HIV Positive/AIDS	Y N	TMJ/Locking Joint	Y N	Sedative	Y N
Diabetes	Y N	Joint Replacement	Y N	Venereal Disease	Y N	Tranquilizer	Y N
Epilepsy/Seizures	Y N	Migraine Headaches	Y N	Cardiovascular Dis.	Y N	**Other Allergies:**	
Fainting/Nervous	Y N	Mitral Valve Prolapse	Y N	(heart attack, angina, coronary, occlusion, arteriosclerosis)		_____	
						_____	

Are you taking birth control pills: ☐ **YES** ☐ **NO**
Are you taking or have you taken Fen-Fen or Redux? ☐ **YES** ☐ **NO**
Do you need to take PRE-MEDICATION before a dental procedure? ☐ **YES** ☐ **NO**

My primary physician is _____ Physician phone number _____

Are you currently taking any medications: YES NO If yes, please list:

_____

Please describe any current medical treatment, impending operations or any other medical or dental information that may possibly affect your dental treatment: _____

Have you traveled out of the country within the last 3 months? Y N If so, to where? _____

The above information is true, correct and complete to the best of my knowledge. I agree to pay my co-payment as well as any and all charges not covered by my insurance company at the time services are rendered. (This office does not mail monthly statements). I understand it is my responsibility to know the fees for services rendered according to my insurance plan.

NOTE: Please confirm your insurance, your benefits and your co-pay prior to your appointment. A delay in verifying your insurance coverage may result in having to reschedule your appointment. **Confirmation of your insurance prior to your appointment is appreciated by our staff, as well as other patients.**

Broken Appointment Policy

All appointment times, in any dental office, are limited and valuable to both the patient and the doctor. It is extremely important that all patients honor their reserved dental appointments. Failure to do so deprives other patients from receiving needed dental care in a timely fashion. **In order to ensure the dentists, staff and other patients will not be penalized by those who fail to keep scheduled appointments, the office policy stipulates that failure to give sufficient notice of canceling or changing an appointment (48 hours) will result in a missed appointment/late cancellation charge of $50.** I understand I am responsible for paying a missed appointment/late cancellation fee **PRIOR** to further services being rendered.

Patient/Parent Signature_____ Date_____

Witness _____ Date _____

I understand that I am responsible for ALL fees regardless of insurance or discount plan coverage. If a parent or legal guardian, I understand that I also am responsible for all fees for services rendered to my child or legal custodian. I realize that I am responsible for all necessary costs of collection, including, but not limited to, reasonable attorney's fees.

Patient/Parent Signature _____ **Date** _____