MICHAEL LUM, D.D.S.
CHARMAINE SINSAY, D.M.D.

426 East Calaveras Blvd. • Milpitas, CA 95035
Tel (408) 262-1710 • www.lumdds.com

Patients Name: _____ Contact Phone: (___)_____

Street Address: _____ Birthdate: _____/_____/_____

City, State, Zip: _____ Social Security #: _____-____-_____

Email: _____ Marital Status: _____

Spouse's Name: _____

(If patient is a minor) Parent's/Guardian's Name: _____

Whom may we thank for referring you to our office: _____

Primary Dental Insurance Information *(Please complete all pertinent information so that we may serve you better.)*

Subscriber's Name: _____
Last Name First Name Middle Name

Relation to Patient _____ Birthdate: ____/____/____ Soc. Sec. #: _____-___-_____

Subscriber Employed By: _____

Employer Address: _____ Telephone: (___)_____

City, State, Zip: _____

Insurance Company: _____ Telephone: (___)_____

Group #: _____ Subscriber ID #: _____

Secondary Dental Insurance Information *Is patient covered by secondary dental insurance coverage? __YES __NO*

Subscriber's Name: _____
Last Name First Name Middle Name

Relation to Patient _____ Birthdate: ____/____/____ Soc. Sec. #: _____-___-_____

Subscriber Employed By: _____

Employer Address: _____ Telephone: (___)_____

City, State, Zip: _____

Insurance Company: _____ Telephone: (___)_____

Group #: _____ Subscriber ID #: _____

In Case of Emergency:

Name: _____ Work Phone: (___)_____ Cell Phone: (___)_____

Primary Physician's Name: _____ Telephone: (___)_____

Medical Insurance ID #: _____ Today's Date: _____/_____/_____

Please answer all the questions

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

yes	no		yes	no		yes	no		yes	no	
☐	☐	Heart Disease or Attack	☐	☐	Diabetes	☐	☐	Asthma	☐	☐	Thyroid Disease
☐	☐	Congenital Heart Defect	☐	☐	Liver Disease	☐	☐	Sinus Trouble	☐	☐	Fainting/Dizzy Spells
☐	☐	Heart Surgery	☐	☐	Hepatitis A (infectious)	☐	☐	Emphysema	☐	☐	Cortisone Medicine
☐	☐	Artificial Heart Valve	☐	☐	Hepatitis B (serum)	☐	☐	Hay Fever	☐	☐	Nervousness
☐	☐	Heart Pacemaker	☐	☐	Cancer	☐	☐	Ulcers	☐	☐	Chronic Headaches
☐	☐	Mitral Valve Prolapse	☐	☐	Chemotherapy	☐	☐	Anemia	☐	☐	Chronic Neckaches
☐	☐	Heart Murmur	☐	☐	Radiation Treatment	☐	☐	Arthritis	☐	☐	Pain in Jaw Joints
☐	☐	High Blood Pressure	☐	☐	AIDS	☐	☐	Glaucoma	☐	☐	Epilepsy or Seizures
☐	☐	Stroke	☐	☐	HIV Positive	☐	☐	Kidney Trouble	☐	☐	Use of Tobacco
☐	☐	Artificial Joint	☐	☐	Blood Transfusion	☐	☐	Psychiatric Treatment	☐	☐	Other not listed
☐	☐	Angina Pectoris/Chest Pains	☐	☐	Hemophilia	☐	☐	Tuberculosis			

yes no

☐ ☐ Have you been under the care of a physician within the past 2 years? (explain) _____

☐ ☐ Have you been hospitalized or had a serious illness within the past 5 years? (explain) _____ date _____

☐ ☐ Do you have any problems with excessive bleeding? (explain) _____

☐ ☐ Have you experienced any ill effects or allergy to any medication
(codeine, aspirin, penicillin, novacaine)? Other _____

☐ ☐ Have you ever been advised not to take a particular medication? (explain) _____

☐ ☐ Have you ever been advised to take prophylactic anibiotics before dental treatment? (explain) _____

☐ ☐ Are you now or have you recently been taking any medication or drugs? (explain) _____

Women only:
yes no

☐ ☐ Are you pregnant? _____ Delivery date/ _____

☐ ☐ Are you breast feeding? _____

☐ ☐ Do you take birth control pills?

_____

Release:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me.
I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand that I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.
I attest to the accuracy of the information on this page.

We value your time. The scheduled time is solely reserved for you. Therefore, we ask for two (2) business days advance notice for any changes in your schedule to avoid a late cancellation fee. In order to keep costs down for our patients, we ask that the estimated co-payment be paid at the time of service. We accept all major credit cards, American Express, Discover, Felxible Spending Debit Cards, Care Credit, and checks. Initial _____

Patient or Parent/Guardian's Signature _____ **Date** _____