	Petaluma O Dr. John S. Woo			nis • Dr. W	/ilson Ng				
, ,,	intment reminder pro Birthdate:	eference? Age:		Phone	atient lives with:	Middle Mom	Dad	Both	
Marital Status of parents: Single Whom may we thank for referring you t		Married		orced	Remarried Patient's Dentis	Other t:			
Responsible Pa Name: Last Address: Home Phone	arty Information	Cell Phone	First City		Work Pl	Middle Zip none	:		
Employer			upation						
Responsible Party' Name: Last Address: Home Phone Employer Relationship to Pat	First Cell Phone Occupation	Middle		Insuran Subscri Subscri Subscri	Insurance Informatice Carrier's Name ber's Full Name: ber's ID# ber's Date of Birth: ber's Employer		Group#		
Medical Histor	·\/							•	
Yes No	у	Yes No			Yes	No			
Fainting/Dizziness Blood Pressure Heart Trouble Prolonged bleeding Rheumatic Fever Snoring		Sleep Apnea Bone disorder Asthma Epilepsy Thyroid Kidneys			163	N D Li Po	Neurological Disorders Diabetes Liver (Hepatitus) Positive HIV Virus (AIDS) Arthritis of any kind		
Is there any other me List any drug allergie	edical problem (or histo es or drug sensitivities ations now being taken		-		?				
Dental History									
Have there been any Thumb of finger suc Are any teeth especi Do the jaw joints ma Is there pain in front Is there dificulty whe Is there tension or sp Is stress or nervous t Are there headaches Have you had a prev	/ injuries to the teeth, n king? Until what age?	ping or gratin ars? wide? eck? oblem? or evening?							
Last dental visit? What are the primary concerns?				Were X-	rays taken?				
what are the primar	y concerns:		N-tr		and the stand of the state				

I authorize Dr. John S. Woo, Dr. Marc deBerardinis and Dr. Wilson Ng to release any information, including diagnosis, records of treatment, examination rendered to my child or me during this period of such dental care to third party payors and/or other health practitioners. I give release for the office to use my photographs and the first initial or name of my child or self for office bulletin displays and/or office websites. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made.

Signature

Please type your name here. Typing your name here will serve as your E-signature.

Date