DR. JESSE CHAI
REGISTRATION & HEALTH HISTORY

In order to render optimum health service, it is necessary to become acquainted with the vital information related to each patient. Of course, all information is strictly confidential.

Please answer every question
Please feel free to ask the receptionist for help in completing this form

NAME: Mr./Mrs./Miss/Ms. _____ S.I.N _____
NAME OF SPOUSE OR NEXT OF KIN _____
HOME # _____ CELL #_____ BUS #_____
BEST # (Circle) (Home) (Cell) (Business) EMAIL ADDRESS _____
HOME ADDRESS _____ APT #_____
CITY _____ POSTAL CODE _____ P.O. BOX_____
EMPLOYER _____BUS ADDRESS_____
OTHER INFO (Car Phone, Spouse Business #) _____
DENTAL INSURANCE COMPANY _____
GROUP/PLAN # _____ CERTIFICATE # _____
POLICY HOLDER _____
SPOUSE INSURANCE COMPANY _____
GROUP/PLAN # _____ CERTIFICATE # _____
Who can we thank for referring you to our office? _____

MEDICAL HISTORY

PHYSICIAN'S NAME _____DATE OF LAST PHYSICAL _____
BIRTHDAY _____ AGE _____

Do you have or have you had any of the following? Please indicate with yes ( ) or no (x)

___ Heart Murmur	___Any heart problems	___High blood pressure
___ Low blood pressure	___Circulatory problems	___Chest pains
___ Shortness of breath	___ Nervous problems	___ Radiation treatments
___Bleeding problems	___Replacement body parts (e.g. knee, limb, heart valve	
___ Epilepsy	___ Fainting	___Allergies to anesthetics
___ Allergies to medicines or drugs	___ Allergies (please specify): _____	
___ Anemea	___ Arthritis	___ Asthma
___ Diabetes	___ Hay Fever	___ Hepatitis
___Hypertension	___ Hyperthyroid	___ Kidney disease
___ Mumps	___ Taking birth control pills	___ Psychiatric care
___ Rheumatic fever	___ Sinus problems	___ Stroke
___ Swelling of the ankles	___ Tonsillitis	___Ulcers
___ Tuberculosis or lung disease		___Pace maker (heart)
___ HIV positive	___ Aids	

Are you pregnant? _____ What month? _____
Are you taking any medication or drugs? _____
Is there anything else you would like us to know? _____

Date _____ Signature_____