Brea Family Dental Center
Kalvin Chen DDS
903 S. Brea Blvd.
Brea CA 92821
(714)529-3184

www.breafamilydental.com

New Patient Form

Chart #. ______
FOR OFFICE USE ONLY

Patient Name: ______ ______ ______ ______
Last | First | MI | Preferred Name

Title: ______ Gender: ○ Male ○ Female Family Status: ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: ______ SS #. ______ Prev. Visit: ______

Email Address: ______ Best time to call: ______

Phone: ______ ______ ______ ______ ______ ______
Home | Work | Ext | Mobile | Fax | Other

Address: ______ ______
______ ______ ______
City | State | Zip Code

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: ______ ______ ______ ______
Last | First | MI | Preferred Name

Who may we thank for referring you today?

______

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Dental Insurance Information

Name of Insured: ______ ______ ______
Last First MI

Insured's Birth Date: ______ ID #. ______ Group #. ______

Insured's Address: ______ ______
______ ______ ______
City State Zip Code

Insured's Employer Name: ______

Employer Address: ______ ______
______ ______ ______
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______

Insurance Address: ______ ______
______ ______ ______
City State Zip Code

Secondary Insurance Information

Name of Insured: ______ ______ ______
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______

As a courtesy, we process dental claims on behalf of our patients. Our office is not responsible for any changes with your dental insurance that may affect your overall out of pocket expenses. It is your responsibility to provide us with up to date dental insurance information. If payment is not received from your dental insurance carrier within 45 days, you may be responsible for the payment of your treatment fees and collection of your benefits directly from your insurance carrier. You will be responsible for any outstanding balance due if your dental insurance company fails to pay.

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Medical Information

- [ ] *Pre-Med - Amox
- [ ] *Pre-Med - Amox
- [ ] *Pre-Med - Clind
- [ ] *Pre-Med - Keflex
- [ ] Allergies
- [ ] Allergy - Amox
- [ ] Allergy - Anesth
- [ ] Allergy - Aspirin
- [ ] Allergy - Codeine
- [ ] Allergy - Erythro
- [ ] Allergy - Keflex
- [ ] Allergy - Latex
- [ ] Allergy - Penicillin
- [ ] Allergy - Sulfa
- [ ] Allergy -Clindamycin
- [ ] Alzheimerz
- [ ] Anemia
- [ ] Angina
- [ ] Art Heart Valve
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Cancer
- [ ] Chemotherapy
- [ ] Diabetes
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Fainting
- [ ] Fibromyalgia
- [ ] Heart Bypass
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV
- [ ] Low Blood Pressure
- [ ] Lupus
- [ ] Mental Disorders
- [ ] Mitral Valve Prolaps
- [ ] Nervous Disorders
- [ ] No Epi
- [ ] Other- See Note
- [ ] Pacemaker
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatism
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Takes Coumadin
- [ ] Transplant
- [ ] Ulcers

Are there any other health conditions we should be aware of:

Please list current medications:

For dental treatment rendered in our office, payment is due at the time of service. We will provide an estimate of dental treatment to you before any dental service is rendered. We will also make sure you understand the cost of such treatment prior to your commitment to treatment.
A fee of $25.00 will be charged for any returned checks.
A fee of $90.00 may be charged to patients who miss or cancel their appointment without 48 hour notice.

I understand and agree to the statements on this form and I have provided accurate information.

Signature: ______________________ Date:

Response Date: