PATIENT INFORMATION

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____ Marital Status: ☐S ☐M ☐Separated/Divorce

Date of Birth: _____ SS #: _____ Gender: ☐ M ☐ F ☐ Other: _____

Email:_____ Home/Cell Phone #: _____

Occupation:_____ Work Phone # : _____

Appointments should be confirmed by ☐ Text ☐ Call Phone ☐ Email

Guarantor: _____ Date of Birth: _____ SS #: _____

Relationship to Patient: _____ Home/Cell Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____

How did you hear about us? ☐ Family/Friend ☐ Insurance Company/ Website ☐ Office Website ☐ Sign ☐ Other: _____

Other Family Members Seen by Us? _____

Emergency Contact: _____ Relationship: _____ Home/Cell Phone #: _____

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____ Group #: _____

Ins. Co. Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____ Insured's ID #: _____

Name of Policy Holder: _____ Insured's Date of Birth: _____

Insured's Employer: _____ Relationship to Patient: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____ Group #: _____

Ins. Co. Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____ Insured's ID #: _____

Name of Policy Holder: _____ Insured's Date of Birth: _____

Insured's Employer: _____ Relationship to Patient: _____

ADDITONAL PATIENT INFORMATION

Name of Pervious Dentist: _____ Phone #: _____

Address: _____City: _____ State: _____ Zip: _____

Approximate Date of last dental treatment: _____ Reason: _____

Physician Name: _____ Phone: _____

Address: _____City: _____ State: _____ Zip: _____

PATIENT AGREEMENT

I release any information needed and authorize assignment of benefits to Dr. Kim Lien Hoang. I understand Dr. Hoang's office will bill my insurance as a courtesy to me; however, I am responsible for all costs of dental treatment rendered. IT IS CUSTOMARY TO PAY AT THE TIME DENTAL SERVICES ARE PROVIDED. A $35 service fee will be charged for checks returned for insufficient funds.

_____ Date: _____

(Signature of Patient, or Guardian)

CONFIDENTIAL HEALTH HISTORY

1. Are you in good health?..... ☐ Yes ☐ No ☐ DK
   If no, please explain: _____
2. Are you now under the care of a physician?..... ☐ Yes ☐ No ☐ DK
   If yes, please explain: _____
3. Have you been hospitalized or had a serious illness in last three years?..... ☐ Yes ☐ No ☐ DK
   If yes, when: _____
4. Have you had any other serious illness or conditions which we should talk about?..... ☐ Yes ☐ No ☐ DK
   If yes, what: _____
5. Are you or have you taken any prescription / over the counter drugs?..... ☐ Yes ☐ No ☐ DK
   Name: _____ Dosage: _____ Reason: _____
   Name: _____ Dosage: _____ Reason: _____
   Name: _____ Dosage: _____ Reason: _____
   Name: _____ Dosage: _____ Reason: _____

6. HAVE YOU HAD ANY ALLERGY OR UNSURAL REACTION TO THE FOLLOWING:

Penicillin ..... ☐ Yes ☐ No
Aspirin ..... ☐ Yes ☐ No
Erythromycin ..... ☐ Yes ☐ No
Codeine ..... ☐ Yes ☐ No
Dental Anesthetic ..... ☐ Yes ☐ No
Latex ..... ☐ Yes ☐ No
Other: _____ ☐ Yes ☐ No

7. HAVE YOU HAD OR DO HAVE ANY OF THE FOLLOWING?

Rheumatic fever or heart murmur? ..... ☐ Yes ☐ No
Heart Surgery/Pacemaker? ..... ☐ Yes ☐ No
Heart trouble or stroke? ..... ☐ Yes ☐ No
High or low blood pressure? ..... ☐ Yes ☐ No
Kidney disease? ..... ☐ Yes ☐ No
Venereal disease? ..... ☐ Yes ☐ No
Tuberculosis, HIV/Aids? ..... ☐ Yes ☐ No
Hepatitis, jaundice or liver disease?..... ☐ Yes ☐ No
Abnormal bleeding problems?..... ☐ Yes ☐ No
Blood disorder? ..... ☐ Yes ☐ No
a) Anemia?..... ☐ Yes ☐ No
b) Clotting problems?..... ☐ Yes ☐ No
c) Other blood problems?..... ☐ Yes ☐ No
Chest pains, ankle swelling or shortness of breath?.....
If yes what: _____ ☐ Yes ☐ No
Emphysema or difficult breathing?..... ☐ Yes ☐ No
Are you a nervous person? ..... ☐ Yes ☐ No
Do you wear contact lenses? ..... ☐ Yes ☐ No
Do you smoke? ..... ☐ Yes ☐ No
If yes, how much: _____

Diabetes? ..... ☐ Yes ☐ No
a) Do you urinate frequently? ..... ☐ Yes ☐ No
b) Are you often thirsty?..... ☐ Yes ☐ No
Stomach or duodenal ulcers? ..... ☐ Yes ☐ No
Cancer or chemotherapy? ..... ☐ Yes ☐ No
Prostate problems? ..... ☐ Yes ☐ No
Osteoporosis?..... ☐ Yes ☐ No
Do you take Forsamax or other meds for Osteoporosis? ...
..... ☐ Yes ☐ No
Arthritis or rheumatism?..... ☐ Yes ☐ No
Artificial joints?..... ☐ Yes ☐ No
Glaucoma?..... ☐ Yes ☐ No
Epilepsy or seizures?..... ☐ Yes ☐ No
Asthma, hey fever, sinus problems or allergies?.....
..... ☐ Yes ☐ No
If yes, what: _____

WOMEN:

Are you pregnant? ..... ☐ Yes ☐ No
Do you take birth control medication? ..... ☐ Yes ☐ No

DENTAL HISTORY

Present dental problems? ..... ☐ Yes ☐ No
Are you currently in pain? ..... ☐ Yes ☐ No
Have you had serious/difficult problems associated with any pervious dental work?..... ☐ Yes ☐ No
Do you ever experience pain, discomfort in your jaw joint? .....
..... ☐ Yes ☐ No
Have you ever had treatments for periodontal disease? .....
..... ☐ Yes ☐ No
If yes, please explain: _____

Do you like your smile? ..... ☐ Yes ☐ No
Do you have sore or sensitive teeth? ..... ☐ Yes ☐ No
Have you had braces (orthodontic treatment)? .... ☐ Yes ☐ No
How many times a day/week do you floss? _____
How many times a day/week do you brush? _____
What type of toothbrush do you use? ☐ Soft ☐ Med ☐ Hard Bristles
Which is most important to you? Check one:
☐ Appearance ☐ Dental Health ☐ Financial Considerations

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

_____ Date: _____
(Signature of Patient, or Guardian)