PATIENT INFORMATION

Name: ______________________________ **Date:** ______________
(Last Name) (First Name) (M.I.)

Address: ______________________________ **SS#:** ______________

City: ____________ **State:** ______ **Zip:** ________ **Phone #:** ______________

Date of Birth: ________________ **M** ☐ **F** ☐ **Marital Status:** ______________

Employer: ______________________________ **Occupation:** ______________

Address: ______________________________ **Work Phone #:** ______________

City: ____________ **State:** ______ **Zip:** ________ **Cell or Pager #:** ______________

Primary Dental Insurance

Insurance Company Name: ______________________________ **Policy #:** ______________

Ins. Co. Address: ______________________________ **Phone#:** ______________

City: ____________ **State:** ______ **Zip:** ________

Name of Policy Holder:: ______________________________
(Last Name) (First Name) (M.I.)

Insured's Date of Birth: ________________ **Insured's SS#:** ______________

Insured's Employer: ________________ **Insured's Relation to the Patient:** ______________

Secondary Dental Insurance

Insurance Company Name: ______________________________ **Policy #:** ______________

Ins. Co. Address: ______________________________ **Phone#:** ______________

City: ____________ **State:** ______ **Zip:** ________

Name of Policy Holder:: ______________________________
(Last Name) (First Name) (M.I.)

Insured's Date of Birth: ________________ **Insured's SS#:** ______________

Insured's Employer: ________________ **Insured's Relation to the Patient:** ______________

Additional Patient Information

Physician's Name: ______________________________ **Phone #:** ______________

Name of Previous Dentist: ______________________________ **Phone #:** ______________

Approximate Date of last dental treatment: ______________________________

Reason for treatment: ______________________________

In Case of Emergency, we should contact Name: ______________________________

Relation to the Patient: ______________________________ **Phone #:** ______________

Whom should we thank for the referral…Name: ______________________________

Family ☐ **Friend** ☐ **Other** ☐ **Insurance Company** ☐ **Office Website** ☐ **Insurance Website** ☐ **Sign** ☐

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 $28 service fee will be charged for checks returned for insufficient funds.

______________________________ **Date:** ______________
(Signature of Patient, or Guardian)

MEDICAL HISTORY

1. Are you in good health? .... Yes No
2. Are you or have you been under the care of a physician? .... Yes No
   If yes, please explain ____________________
3. Have you been hospitalized or had serious illness? .... Yes No
   When________________ What ________________
4. Are you or have you taken any prescription/over the counter drugs? .... Yes No
   If yes, please list:
   Name:______________ Dosage: ______________ Reason for taking: ______________
   ______________ ______________
5. Have you had any allergy or unusual 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
Tuberculosis, HIV/Aids	Yes	No
6. Hepatitis, jaundice or liver disease?	Yes	No
7. Rheumatic fever or heart murmur?	Yes	No
8. Heart surgery/Pacemaker?	Yes	No
9. Heart trouble or stroke?	Yes	No
10. Do any blood relatives have heart trouble	Yes	No
11. High or low blood pressure?	Yes	No
12. Chest pains, ankle swelling or shortness of breath?	Yes	No
If yes, what: ______________		
13. Emphysema or Difficult Breathing?	Yes	No
14. Epilepsy or seizures?	Yes	No
15. Asthma, hay fever, sinus problems or allergies?	Yes	No
If yes, what: ______________		
16. Diabetes?	Yes	No
a) Any blood relatives?	Yes	No
b) Do you urinate frequently??	Yes	No
c) Are you often thirsty?	Yes	No
17. Arthritis or rheumatism?	Yes	No
18. Stomach or duodenal ulcers?	Yes	No
19. Kidney disease or infection?	Yes	No
20. Venereal disease?	Yes	No
21. Cancer or chemotherapy?	Yes	No
22. Osteoporosis? Fosomax or others	Yes	No
Codeine	Yes	No
Dental Anesthetic	Yes	No
Latex	Yes	No
23. Glaucoma?	Yes	No
24. Prostate problems?	Yes	No
25. Abnormal bleeding problems	Yes	No
blood disorder	Yes	No
a) Anemia?	Yes	No
b) Clotting problems?	Yes	No
c) Other blood problems?	Yes	No
26. Are you taking???	Yes	No
27. Are you nervous person?	Yes	No
28. Do you wear contact lenses?	Yes	No
29. Have you had any other serious illness or conditions which. we should know about?	Yes	No
If yes, what:		
30. Do you smoke?	Yes	No
31. If yes, how much?		

Women:

32. Are you pregnant?	Yes	No
33. Do you take birth control medication?	Yes	No
34. Artificial bones or joints?	Yes	No

DENTAL HISTORY

1. Present dental problems
2. Are you currently in pain? .... Yes No
3. Have you ever had a serious/difficult problem associated with any previous dental work? .... Yes No
4. Do you or have you ever experienced pain, discomfort in your jaw joint? .... Yes No
5. Does your gum bleed? .... Yes No
   Have you ever had treatments for periodontal disease?
   If yes please explain .... Yes No
6. Do you like your smile? .... Yes No
7. Do you have sore or sensitive teeth? .... Yes No
8. Have you ever had braces (orthodontic treatment)? .... Yes No
9. How many times a week do you floss? ______________
10. How many times a day do you brush? ______________
11. Type of toothbrush? Hard ☐ Med ☐ Soft ☐
12. What is important to you? Circle 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 the staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

____

Signature of Patient or Guardian Date

OFFICE USE ONLY

Date & Signature ______________ Med Hx Review ______________

Date & Signature ______________ Med Hx Review ______________

Date & Signature ______________ Med Hx Review ______________

Date & Signature ______________ Med Hx Review ______________