WELCOME TO JUST DENTAL (DUC DO DDS, INC.)

PATIENT INFORMATION

Today's Date: _____

Patient Name: _____

Sex: ☐M ☐F ☐N/A DOB: _____

Social Security #: _____

Address: _____

_____

Cell: _____ Work: _____

Language (s) Spoken: _____

Are you currently pregnant? ☐Yes ☐No

Are you currently smoking? ☐Yes ☐No

In Case of Emergency, Please Contact:

Phone #: _____ Name: _____

Relationship: _____

How did you hear about us? _____

Reason for today's visit _____

_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assigned directly to Dr. Duc H. Do all insurance benefits. If any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____

Date: _____

DENTAL INSURANCE

Insurance Co. Name: _____

Subscriber Name: _____

Subscriber ID: _____

Subscriber DOB: _____

Group No.: _____

Patient Relation to Subscriber:

Self Spouse Dependent Other

How many insurances that you have? _____

Additional Insurance Information:

_____

_____

_____

MEDICATIONS

Current medications you are taking:

_____

_____

Pharmacy Name: _____Tel: _____

Address: _____

Allergies:

☐Unknown Drug Allergy

☐Local Anesthetics

☐Amoxicillin / Penicillin

☐Barbiturates (Sleeping pills)

☐Sulfa ☐Aspirin ☐Latex

Other:

_____

_____

DENTAL HISTORY

Reason for today visit: _____

How often do you brush? _____ How often do you floss? _____

Date of last dental care: _____ Former dentist: _____

(Please check "Yes" or "No")

Bad breath	☐Y ☐N	Grinding teeth	☐Y ☐N	Periodontal treatment	☐Y ☐N
Bleeding gums	☐Y ☐N	Gums swollen	☐Y ☐N	Sensitivity to cold	☐Y ☐N
Blisters on lips/mouth	☐Y ☐N	Jaw pain	☐Y ☐N	Sensitivity to heat	☐Y ☐N
Broken Fillings	☐Y ☐N	Loose teeth	☐Y ☐N	Sensitivity to sweets	☐Y ☐N
Clicking or popping jaw	☐Y ☐N	Mouth pain	☐Y ☐N	Sensitivity to biting	☐Y ☐N
Dry mouth	☐Y ☐N	Orthodontic treatment	☐Y ☐N	Sores in mouth	☐Y ☐N
Foods between teeth	☐Y ☐N	Pain around ear	☐Y ☐N		

MEDICAL HISTORY

(Please check "Yes" or "No")

Anemia	☐Y ☐N	Epilepsy	☐Y ☐N	Respiratory Disease	☐Y ☐N
Arthritis	☐Y ☐N	Fainting	☐Y ☐N	Rhematic Fever	☐Y ☐N
Artificial Heart Valves	☐Y ☐N	Glaucoma	☐Y ☐N	Scarlet Fever	☐Y ☐N
Artificial Joints	☐Y ☐N	Headaches	☐Y ☐N	Shortness of Breath	☐Y ☐N
Asthma	☐Y ☐N	Heart Murmur	☐Y ☐N	Skin Rash	☐Y ☐N
Back Problems	☐Y ☐N	Heart Problems	☐Y ☐N	Stroke	☐Y ☐N
Blood Disease	☐Y ☐N	Hemophilia	☐Y ☐N	Swelling of Feet/Ankles	☐Y ☐N
Cancer	☐Y ☐N	Hepatitis	☐Y ☐N	Thyroid Problems	☐Y ☐N
Chemical Dependency	☐Y ☐N	High Blood Pressure	☐Y ☐N	Tobacco Habit	☐Y ☐N
Chemotherapy	☐Y ☐N	HIV/AIDS	☐Y ☐N	Tonsillitis	☐Y ☐N
Circulatory Problems	☐Y ☐N	Kidney Disease	☐Y ☐N	Tuberculosis	☐Y ☐N
Cortisone Treatments	☐Y ☐N	Liver Disease	☐Y ☐N	Ulcer	☐Y ☐N
Cough	☐Y ☐N	Mitral Valve Prolapse	☐Y ☐N	Venereal Disease	☐Y ☐N
Cough up Blood	☐Y ☐N	Pacemaker	☐Y ☐N		
Diabetes	☐Y ☐N	Radiation Treatment	☐Y ☐N		

SIGNATURE

☐ To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guadian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative Date