

**NEW PATIENT FORM**

**Name** \_\_\_\_\_  Male  Female  
                    **Last**                                    **First**                                    **MI**

**Address** \_\_\_\_\_  
                    **Street**                                    **Apt**                                    **City**                                    **Zip**

**Telephone (Home)** \_\_\_\_\_ **(CELL)** \_\_\_\_\_ **SS#** \_\_\_\_\_

**Birth Date** \_\_\_/\_\_\_/\_\_\_ **Driver's License #** \_\_\_\_\_ **State issue** \_\_\_ **EMAIL** \_\_\_\_\_

Primary Dental Insurance			Secondary Dental Insurance		
_____	_____	_____	_____	_____	_____
Last	First	MI	Last	First	MI
_____	_____	_____	_____	_____	_____
Street	City	State Zip	Street	City	State Zip
_____	_____	_____	_____	_____	_____
Birthdate	Relationship to Patient		Birthdate	Relationship to Patient	
_____	_____	_____	_____	_____	_____
Employer	Dental Ins. Comp		Employer	Dental Insurance Comp	
_____	_____	_____	_____	_____	_____
Subscriber#	Group#		Subscriber#	Group#	

**We can bill certain dental procedures to your Medical insurance**

Primary Medical Insurance			Secondary Medical Insurance		
_____	_____	_____	_____	_____	_____
Last	First	MI	Last	First	MI
_____	_____	_____	_____	_____	_____
Street	City	State Zip	Street	City	State Zip
_____	_____	_____	_____	_____	_____
Birthdate	Relationship to Patient		Birthdate	Relationship to Patient	
_____	_____	_____	_____	_____	_____
Subscriber#	Group#		Subscriber#	Group#	

**Person to contact in case of emergency:**

Name: \_\_\_\_\_ Tel: \_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_

**Authorization:**

I hereby authorize payment directly to Dr. Nguyen or Dr. Phung of the Group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of the dental treatment. I hereby authorize Healthy Smile Dentistry to administer such medications and perform such diagnostic, phot ographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to the third party payors and/other health professionals

**X** \_\_\_\_\_

**Patient or Responsible Party**

**Date**

**NAME**

**Date**

**Dental History**

**Please Circle**

Do you have a specific dental problem? Describe \_\_\_\_\_ Yes No

Do you have dental examinations on a routine basis? Last visit \_\_\_\_\_ Yes No

Do you think you think you have active decay or gum disease? \_\_\_\_\_ Yes No

Do you brush and floss on a routine basis? Discuss \_\_\_\_\_ Yes No

Do your gums ever bleed? Discuss \_\_\_\_\_ Yes No

Do you like your smile? Why? \_\_\_\_\_ Yes No

Does food catch between your teeth? \_\_\_\_\_ Yes No

Do you ever have clicking, popping, or discomfort in the jaw joint? \_\_\_\_\_ Yes No

Do you smoke or chew tobacco? \_\_\_\_\_ Yes No

Has your past experience in a dental office always positive? \_\_\_\_\_ Yes No

Name of previous dentist (optional): \_\_\_\_\_ Yes No

Date of last full mouth Xray (18 small xray or Panoramic) \_\_\_\_\_ Yes No

**Medical History**

Are you under a physician's care now? Why? \_\_\_\_\_ Who? \_\_\_\_\_ Phone# \_\_\_\_\_ Yes No

Have you ever been or recently hospitalized or had a major operation? Discuss \_\_\_\_\_ Yes No

Have you ever had a serious injury to your head or neck? Discuss \_\_\_\_\_ Yes No

Are you taking any medications? What? \_\_\_\_\_ Yes No

Women (Please check):  Pregnant/ Trying to get pregnant  Nursing  Taking oral contraceptive Yes No

Are you allergic to any medication or substance? Please check box below \_\_\_\_\_ Yes No

Penicillin  Codeine  Latex  Metal  Peanuts Other \_\_\_\_\_ Yes No

Do you now have or have you ever had any of the following? Please circle

Heart Trouble	Yes No	Sickle Cell anemia	Yes No	Renal Dialysis	Yes No	Hepatitis A,B,C	Yes No	Arthritis/Gout	Yes No
Heart Attack/Failure	Yes No	Excessive Bleeding	Yes No	Thyroid problem	Yes No	Venereal disease	Yes No	Cortizone Shot	Yes No
Heart surgery	Yes No	Shortness of Breath	Yes No	Parathyroid issue	Yes No	HIV/AIDS	Yes No	Cancer	Yes No
Heart pace maker	Yes No	Tuberculosis	Yes No	Excessive thirst	Yes No	Psychiatric problem	Yes No	Leukemia	Yes No
Mitral Valve prolapsed	Yes No	Pneumonia	Yes No	Hypoglycemia	Yes No	Epilepsy/Seizures	Yes No	Radiation/Chemo	Yes No
High blood pressure	Yes No	Asthma	Yes No	Liver disease	Yes No	Drug Addiction	Yes No	Artificial joint	Yes No
Low blood pressure	Yes No	Kidney problem	Yes No	Diabetes	Yes No				
Bruise easily	Yes No								

Have you ever had any other serious illness not checked above? Discuss \_\_\_\_\_ Yes No

Do you wish to talk to the dentist privately about any problem? \_\_\_\_\_

X \_\_\_\_\_ Patient/Parent or Guardian Date \_\_\_\_\_

Reviewed by Doctor \_\_\_\_\_ Date \_\_\_\_\_