Patient Information *(Confidential)*

Today's Date ___________

Name _______________ Birthdate _______________ SS# _______________

Address _______________ City _______________ State ________ Zip ________

Home Phone _______________ Work Phone _______________

Cell Phone _______________ E-mail _______________

Employer _______________ Work Phone _______________

Business Address _______________ City _______________ State ________ Zip ________

Spouse/Parent's Name _______________ Employer _______________ Work Phone _______________

If Student, Name of School/College _______________ City _______________ State ______ ☐ Full Time ☐ Part Time

Person to Contact in Case of Emergency _______________

Relationship to Patient _______________ Phone _______________

Whom Shall We Thank For Your Referral _______________

Appointment Reminder ☐ via Email ☐ Phone call ☐ SMS/Text Message (Phone Carrier) _______________

Responsible Party

Name of Person responsible for this Account _______________ Relationship to Patient _______________

Address _______________ Phone _______________

Employer _______________ Phone _______________

Driver's License# _______________ Birthdate _______________ SS# _______________

Insurance Information *(All about insured)*

Name of Insured _______________ Relationship to Patient _______________

Birthdate _______________ SS# _______________ Phone _______________

Insurance Company _______________ Phone _______________

Name of Employer _______________ Phone _______________

Smile Analysis

How can Dr. Nguyen transform your smile from dull to dazzling!

	Y	N		Y	N
Do you Feel Your teeth are too small or too large?	☐	☐	Are There spaces in between your teeth?	☐	☐
Have your gums receded or do they appear red or puffy?	☐	☐	Do your teeth slant one way or another?	☐	☐
Do you show too much gum when you smile?	☐	☐	Are any of your teeth yellow, dark, or stained?	☐	☐
Are any teeth crooked, missing, irregular shaped, or out of line?	☐	☐	Do you have any teeth with old fillings that are stained gray?	☐	☐
Do you grind your teeth or are any of the biting edges of your teeth chipped?	☐	☐	Are the edges of any of your teeth even with your other teeth	☐	☐
Are you unhappy with any crowns that are in your mouth?	☐	☐	Are you canine teeth sharp, worn, or look out of line?	☐	☐

MEDICAL HISTORY

PATIENT NAME ______________________________ Birth Date ______________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ____________

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ____________

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ____________

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ____________

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ____________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ____________

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: ____________

Do you have, or have you had, any of the following?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV Positive	◯	◯	Cortisone Medicine	◯	◯	Hemophilia	◯	◯	Radiation Treatments	◯	◯
Alzheimer's Disease	◯	◯	Diabetes	◯	◯	Hepatitis A	◯	◯	Recent Weight Loss	◯	◯
Anaphylaxis	◯	◯	Drug Addiction	◯	◯	Hepatitis B or C	◯	◯	Renal Dialysis	◯	◯
Anemia	◯	◯	Easily Winded	◯	◯	Herpes	◯	◯	Rheumatic Fever	◯	◯
Angina	◯	◯	Emphysema	◯	◯	High Blood Pressure	◯	◯	Rheumatism	◯	◯
Arthritis/Gout	◯	◯	Epilepsy or Seizures	◯	◯	High Cholesterol	◯	◯	Scarlet Fever	◯	◯
Artificial Heart Valve	◯	◯	Excessive Bleeding	◯	◯	Hives or Rash	◯	◯	Shingles	◯	◯
Artificial Joint	◯	◯	Excessive Thirst	◯	◯	Hypoglycemia	◯	◯	Sickle Cell Disease	◯	◯
Asthma	◯	◯	Fainting Spells/Dizziness	◯	◯	Irregular Heartbeat	◯	◯	Sinus Trouble	◯	◯
Blood Disease	◯	◯	Frequent Cough	◯	◯	Kidney Problems	◯	◯	Spina Bifida	◯	◯
Blood Transfusion	◯	◯	Frequent Diarrhea	◯	◯	Leukemia	◯	◯	Stomach/Intestinal Disease	◯	◯
Breathing Problem	◯	◯	Frequent Headaches	◯	◯	Liver Disease	◯	◯	Stroke	◯	◯
Bruise Easily	◯	◯	Genital Herpes	◯	◯	Low Blood Pressure	◯	◯	Swelling of Limbs	◯	◯
Cancer	◯	◯	Glaucoma	◯	◯	Lung Disease	◯	◯	Thyroid Disease	◯	◯
Chemotherapy	◯	◯	Hay Fever	◯	◯	Mitral Valve Prolapse	◯	◯	Tonsillitis	◯	◯
Chest Pains	◯	◯	Heart Attack/Failure	◯	◯	Osteoporosis	◯	◯	Tuberculosis	◯	◯
Cold Sores/Fever Blisters	◯	◯	Heart Murmur	◯	◯	Pain in Jaw Joints	◯	◯	Tumors or Growths	◯	◯
Congenital Heart Disorder	◯	◯	Heart Pacemaker	◯	◯	Parathyroid Disease	◯	◯	Ulcers	◯	◯
Convulsions	◯	◯	Heart Trouble/Disease	◯	◯	Psychiatric Care	◯	◯	Venereal Disease	◯	◯
									Yellow Jaundice	◯	◯

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ____________

Comments: ____________

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________________ DATE ____________

Patient Dental History

Name of Previous Dentist and Location ______________________________________ Date of Last Exam _____________

	Y	N		Y	N
Do your gums bleed while you brush?	☐	☐	Do you have frequent headaches?	☐	☐
Are your teeth sensitive to hot or cold liquids/food?	☐	☐	Do you clench or grind your teeth?	☐	☐
Are your teeth sensitive to sweets/sour liquids/food?	☐	☐	Do you bite your lips or cheeks frequently?	☐	☐
Do you feel pain in any of your teeth?	☐	☐	Have you ever had difficult extractions or prolonged bleeding in the past?	☐	☐
Do you have any sores or bumps in or near your mouth?	☐	☐	Have you had orthodontic treatment?	☐	☐
Have you had any head, neck, or jaw injuries?	☐	☐	Do you wear dentures or partials? If yes Date of placement? ___________________	☐	☐
Have you ever had any clicking, pain in the TMJ area or difficulty opening or closing of your jaw?	☐	☐			

Authorization and Release

- I certify that I have read and understand the above information to the best of my knowledge. I have answered the above questions to the best of my knowledge. I understand providing incorrect information can be dangerous to my health. I will inform Dr. Nguyen and the staff of any medical changes at my next appointment if there are any.
- I authorize Dr. Nguyen and his staff to take x-rays, models, photos and/or other diagnostic aids necessary for a thorough diagnosis of myself and/or my minor dependents listed on this form.
- I also authorize Dr. Nguyen to release any such information to third party payors and/or healthcare practitioners for the purpose of rendering treatment, payment activities and healthcare operations.
- I understand and acknowledge that Dr. Nguyen may use my photographs in her marketing campaign for educational purposes to potential patients.
- I understand that my dental insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.
- I authorize my insurance company to pay directly to LIfe Dental/ Dr. Nguyen.

Signature of patient/parent of minor ______________________________________ Date ____________________

Medical Update (for office use only) ____

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