WELCOME TO FINE DENTISTRY

PATIENT INFORMATION		DENTAL INSURANCE				
Today 's date		Who is responsible	le for this account			
Patient 's name		Relationship to patient Insurance Co.				
Address —						
City State —	Zip	Insurance ID# —	Group # —			
Email : @		Additional denta	l insurance? Yes No			
Sex: M F Age		Subscriber's Nar	me			
Birthdate		Birthdate	SS#			
Married Single Widow Separa	ated Divorced	Relationship to F	Patient			
Occupation			Group #			
		ASSESSMENT OF THE PARTY.	EVALUACIONE DE LE CONTRACTO DE SAL MENTE			
Patient Employer/School		ASSIGNMENT AND RE	ELEASE			
Employer/School Phone		I certify that I, and/or my dependent(s), have insurance coverage with the insurance named above and assign directly to Dr. Henry Phan all insurance benefits, if any, otherwise payable to me for services endered. I understand that I am financially responsible for all charges whether or not paid by insurance. I author/zed the				
Spouse's Name	. Birthdate	use of my signature on all in				
Spouse SS#		Dr. Henry Phan may use my health care information and may disclose such information to the above-named Insurance Company(ies) and theirs agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for the related services. This consent will end when my current treatment plan is completed or one year from the date signed below.				
Spouse's employer						
		Signat	ture of Patient, Parent, Guardian or Personal Representative			
Whom may we thank for referring you?	THE PARTY OF THE P	Эјуна	agnature or ratient, ratera, obaituan ur resonta representative			
	()	Please prin	nt name of Patient, Parent, Guardian or Personal Representative			
		Date	Relationship to Patient			
		Daro	Heldoriship o r Stein			
PHONE NUMBERS						
Home	Work		Cell			
Spouse's Work	Best time and place t	o reach you				
IN CASE OF EMERGENCY, CONTACT	(Specify someone wh	no does not live in yo	our household.)			
Name	Relationship					
Home	Work		Cell			
DENTAL HISTORY	Please circle Y	to indicate <u>if you ha</u>	ave had any of the following			
Reason for today's visit:	Sensitivity to cold	4 Y 2	Bad breath			
	_ Sensitivity to heat	Υ	Bleeding when brushing/flossing Y			
Former Dentist	Sensitivity to sweets	Υ	Pain when brushing/flossing Y			
	Sensitivity when biting	Υ	Loose teeth or broken filling Y			
City/State	_ Throbbing tooth pain	Y	Gum swollen or tender			
Data of last deptal visit	Jaw pain or tiredness	Υ	Periodontal treatment Y			
Date of last dental visit	Clicking/popping jaw	EY K	Food collection between teeth Y			
Date of last dental Xray	— Pain around ear	Υ	Blister on lip or mouth Y			
Usus allers de vous benefit	Frequent headache	Y	Sores or growths in your mouth Y			
How often do you brush	Grinding/clenching teeth	Υ	Burning sensation on tongue Y			
How often do you floss	9					
	Chew on one side mostly	Υ	Cigarette/cigar smoking			
If you had orthodontic treatment, in		Y	Cigarette/cigar smoking Y Tobacco chewing Y			

Prome if prognant – due day? — Taking trint control pill? Y N Baby Nursing? Y N Please gircle Y to Indicate if you have had any of the following AIDSHIV Y Diabetes, type	MEDICAL HISTORY					
Please circle Y to Indicate if you have had any of the following AIDS/HIV Y Diabetes, type Y Anemia Y Hepstitis , type Y Swolen Feet or Antices Y Blood Disease Y Herpes Y Special Diet Y Blood dotting problem Y Veneral Disease Y Special Diet Y Blood dotting problem Y Veneral Disease Y Special Diet Y Blood dotting problem Y Arthritis, Rhouradism Y Kidney Disease Y Epilepsy Y Arthritis, Rhouradism Y Liver Disease Y Back problem Y Arthridal Heart Valves Y Jaundicé Y Headstohes Y Jaundicé Y Headstohes Y Jaundicé Y Headstohes Y Jaw pain Y Heat Murmur Y Cherrotherapy Y Nervous problem Y Pacemaker Y Radiation Treatment Y Psychiatric care Y Congenital Heart Defect Y Tumo; on head, or neck Y Glaucoma Y Circulatory problems Y Heat problems Y Respiratory Disease Y Tonsilitis Y Heat problems Y Respiratory Disease Y Tonsilitis Y Heat problems Y Respiratory Disease Y Tonsilitis Y Heat problems Y Emphysema Y Chemical Dependency Y Feinting or dizziness Y Tuberculosis Y Cortisone treatment Y Shortness of breath Y Persistent or Bloody Cough Y Taking "fen-phen" drug Y MEDICATIONS Liver Disease Phone	Physician's name	Phone #		Date of last visit _		
AIDS/HIV Y Diebetes, type Y Anemia Y Hepatitis , type Y Swolen Feet or Ankles Y Blood Disease Y Herpes Y Spedal Diet Y Blood Disease Y Herpes Y Spedal Diet Y Blood dotting problem Y V Venereal Disease Y Skin rath Y Stroke Y Arthrids, Rheumatism Y Kidney Disease Y Epilepsy Y Arthrids Heart Valves Y Jaundice Y Headaches Y Headaches Y Jaundice Y Headaches Y Milrial Valve Prolapse Y Cancer Y Jaw pain Y Headaches Y Milrial Valve Prolapse Y Cancer Y Jaw pain Y Pacemaker Y Radiation Treatment Y Psychiatric care Y Congenital Heart Defect Y Tumor pin head,or neck Y Gleucoma Y Rheumatic Fever Y Swollan Neck Gland Y Scrafter Fever Y Swollan Neck Gland Y Scrafter Fever Y Heart problems Y Heart problems Y Respiratory Disease Y Tonsilitis Y Chemical Dependency Y Emphysema Y Chemical Dependency Y Tonsilitis Y Respirators of breath Y Persistent or Bloody Cough Y Taking Ten-phen' dug Y Persistent or Bloody Cough Y Taking Ten-phen' dug Y Persistent or Bloody Cough Y Taking Ten-phen' dug Y Persistent or Bloody Cough Y Taking Ten-phen' dug Y Persistent or Bloody Cough Y Taking Ten-phen' dug Y Persistent or Bloody Cough Y Taking Ten-phen' dug Y Persistent or Bloody Cough Y Taking Ten-phen' dug Y Persistent or Bloody Cough Y Taking Ten-phen' dug Y Persistent or Bloody Cough Y Taking Ten-phen' dug Y Persistent or Bloody Cough Y Taking Ten-phen' dug Y Persistent or Bloody Cough Y Taking Ten-phen' dug Y Persistent or Bloody Cough Y Taking Ten-phen' dug Y Persistent or Bloody Cough Y Taking Ten-phen' dug Y Persistent or Bloody Cough Y Taking Ten-phen' dug Y Persistent or Bloody Cough Y Taking Ten-phen' dug Y Persistent or Bloody Cough Y Taking Ten-phen' dug Y Persistent or Bloody Cough Y Taking Ten-phen' dug Y Persistent or Bloody	Women: If pregnant – due day?	Taking birth control pill?	Y N	Baby Nursing?	Y N	
Hepatitis , type	Please g	circle Y to indicate if you have	had any of the follo	owing		
Herpes Y Special Diet Y Blood dotting problem Y Venereal Disease Y Skin rash Y Stroke Y Arthritis, Rheumatism Y Kidney Disease Y Epilepsy Y Artificial Joints Y Liver Disease Y Back problem Y Artificial Joints Y Liver Disease Y Back problem Y Artificial Joints Y Liver Disease Y Back problem Y Artificial Heart Valve Prolapse Y Jaundice Y Headeches Y Jaundice Y Headeches Y Java pain Y Headeches Y Marvous problem Y Pacemaker Y Cancer Y Jaw pain Y Nervous problem Y Pacemaker Y Radiation Treatment Y Psychistric care Y Congenital Heart Defect Y Tumor on head or neck Y Glaucoma Y Rheumatc Fever Y Swellen Neck Gland Y Scarlet Fever Y Circulatory problems Y Ulcer Y Thyroid problems Y Heat problems Y Respiratory Disease Y Tonsitits Y High Blood Pressure Y Respiratory Disease Y Tonsitits Y High Blood Pressure Y Emphysema Y Chemical Dependency Y Fainting or dizziness Y Tuberculosis Y Contisone treatment Y Shortness of breath Y Persistent or Bloody Cough Y Taking "fen-phen" drug Y MEDICATIONS Please list medications currently taking and reasons? Pencilin Sulfa Latex Barbiturates Codein Aspirin Iodine Local anesthetic Others Pharmacy Name Phone Date Understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status Signature of patient or guardian Date OFFICE USE ONLY Date Medical History Review communit Dector's Signature/Initial	AIDS/HIV.	Diabetes, type	Na Y ara da f	Anemia	Y 1	
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Artificial Heart Valves Y	Arthritis, Rheumatism Y	Kidney Disease	Y. Dieter	Epilepsy	Y	
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Fainting or dizziness Y Tuberculosis Y Cortisone treatment Y Shortness of breath Y Persistent or Bloody Cough Y Taking "fen-phen" drug Y MEDICATIONS Please list medications currently taking and reasons? Penicilin Sulfa Latex Barbiturates Codein Aspirin Iodine Local anesthetic Others Understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status Signature of patient or guardian Date Medical History Review comment Doctor 's Signature/Initial Date Medical History Review comment Doctor 's Signature/Initial	High Blood Pressure Y	Asthma	* Y	Weight Loss, unexpl	ained Y	
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