

WELCOME TO FINE DENTISTRY

PATIENT INFORMATION

Today's date _____

Patient's name _____

Address _____

City _____ State _____ Zip _____

Email : _____ @ _____

Sex: M F Age _____

Birthdate _____

Married Single Widow Separated Divorced

Occupation _____

Patient Employer/School _____

Employer/School Phone _____

Spouse's Name _____ Birthdate _____

Spouse SS# _____

Spouse's employer _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account _____

Relationship to patient _____

Insurance Co. _____

Insurance ID# _____ Group # _____

Additional dental insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____ Group # _____

ASSIGNMENT AND RELEASE

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 rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorized the use of my signature on all insurance submissions.

Dr. Henry Phan may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their 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.

Signature of Patient, Parent, Guardian or Personal Representative

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

Date

Relationship to Patient

PHONE NUMBERS

Home _____ Work _____ Cell _____

Spouse's Work _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home _____ Work _____ Cell _____

DENTAL HISTORY

Please circle Y to indicate if you have had any of the following

Reason for today's visit: _____	Sensitivity to cold Y	Bad breath Y
_____	Sensitivity to heat Y	Bleeding when brushing/flossing Y
_____	Sensitivity to sweets Y	Pain when brushing/flossing Y
Former Dentist _____	Sensitivity when biting Y	Loose teeth or broken filling Y
City/State _____	Throbbing tooth pain Y	Gum swollen or tender Y
Date of last dental visit _____	Jaw pain or tiredness Y	Periodontal treatment Y
_____	Clicking/popping jaw Y	Food collection between teeth Y
Date of last dental Xray _____	Pain around ear Y	Blister on lip or mouth Y
How often do you brush _____	Frequent headache Y	Sores or growths in your mouth Y
_____	Grinding/clenching teeth Y	Burning sensation on tongue Y
How often do you floss _____	Chew on one side mostly Y	Cigarette/cigar smoking Y
_____	Dry mouth Y	Tobacco chewing Y
If you had orthodontic treatment, in what year _____	Mouth breathing Y	Foreign objects in the mouth Y

MEDICAL HISTORY

Physician's name _____

Phone # _____

Date of last visit _____

Women: If pregnant - due day? _____

Taking birth control pill? Y N

Baby Nursing? Y N

Please circle Y to indicate if you have had any of the following

AIDS/HIV	Y	Diabetes, type	Y	Anemia	Y
Hepatitis, type	Y	Swollen Feet or Ankles	Y	Blood Disease	Y
Herpes	Y	Special Diet	Y	Blood clotting 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 Heart Valves	Y	Jaundice	Y	Headaches	Y
Mitral Valve Prolapse	Y	Cancer	Y	Jaw pain	Y
Heart Murmur	Y	Chemotherapy	Y	Nervous problem	Y
Pacemaker	Y	Radiation Treatment	Y	Psychiatric care	Y
Congenital Heart Defect	Y	Tumor on head or neck	Y	Glaucoma	Y
Rheumatic Fever	Y	Swollen Neck Gland	Y	Scarlet Fever	Y
Circulatory problems	Y	Ulcer	Y	Thyroid problems	Y
Heart problems	Y	Respiratory Disease	Y	Tonsillitis	Y
High Blood Pressure	Y	Asthma	Y	Weight Loss, unexplained	Y
Low Blood Pressure	Y	Emphysema	Y	Chemical Dependency	Y
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? _____

Pharmacy Name _____ Phone _____

ALLERGIES

(Please circle if indicated)

Penicilin	Sulfa	Latex	Barbiturates
Codein	Aspirin	Iodine	Local anesthetic
Others _____			

I 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 comment

Doctor's Signature/Initial

Date

Medical History Review comment

Doctor's Signature/Initial

Date

Medical History Review comment

Doctor's Signature/Initial