Healthy Smile Dentistry

(951) 246-8242

PERSONAL INFORMATION

DATE _____

NAME _____ ☐MALE ☐FEMALE
LAST FIRST MI

ADDRESS _____
STREET APT.# CITY STATE ZIP

TELEPHONE (Home) _____ (Work) _____ (Cell) _____

BIRTHDATE _____ / _____ / _____ Driver's License # _____ State Issued _____
MONTH DATE YEAR

PLACE OF EMPLOYMENT _____ SS# _____

IF FULL TIME STUDENT, SCHOOL NAME _____

PERSON RESPONSIBLE FOR ACCOUNT–PLEASE CHECK ONE: ☐ PATIENT ☐ GUARDIAN ☐ SPOUSE ☐ FATHER ☐ MOTHER

INSURANCE INFORMATION

MINORE CHILD – MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS – COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR REPSONSIBLE PARTY

LAST FIRST MI

STREET CITY STATE ZIP

HOME# WORK# FAX# EMAIL

BIRTHDATE RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO.

SS# SUBSCRIBER# GROUP#

SECONDARY INSURED

LAST FIRST MI

STREET CITY STATE ZIP

HOME# WORK# FAX# EMAIL

BIRTHDATE RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO.

SS# SUBSCRIBER# GROUP#

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family Household

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

Has any member of your family ever been treated in our office?
☐ Yes ☐ No
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, photographic 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 third party payors and/or other health professionals

X _____
Patient or Responsible Party Date

PATIENT NAME _____ DATE _____

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

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 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? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? _____ Yes No
Name of previous dentist (optional): _____ Yes No
Date of last full mouth x-rays (16 small films or panoramic) _____ Yes No

Medical History

Are you under a physician's care now? Why? _____ Who? _____ Phone # _____ Yes No
Have you ever been 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, pills or drugs? What? _____ Ever taken fen-phen?* _____ Yes No
Are you on a special diet? Discuss _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other _____

Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss _____ Yes No

Do you now have or have you ever had any of the following? Please check the appropriate boxes.
*If yes to any of the starred conditions, please call prior to your appointment...premedication may be required.

Heart Trouble/Disease	Y N	Bruise Easily	Y N	Emphysema	Y N	Renal Dialysis	Y N	Cancer	Y N
Heart Murmur*	Y N	Psychiatric Problems	Y N	Tuberculosis	Y N	Parathyroid Disease	Y N	Glaucoma	Y N
Irregular Heart Beat	Y N	Excessive Bleeding	Y N	Bloody Sputum	Y N	Arthritis/Gout	Y N	Anemia	Y N
Angina/Chest Pain	Y N	Sickle Cell Disease	Y N	Chemotherapy	Y N	Rheumatism	Y N	Asthma	Y N
Heart Attack/Failure	Y N	Hemophilia	Y N	Thyroid Disease	Y N	Cortisone Medicine	Y N	Ulcers	Y N
Congenial Heart Disorder	Y N	Yellow Jaundice	Y N	High Blood Pressure	Y N	Artificial Joint*	Y N	Stroke	Y N
Mitral Valve Prolapse*	Y N	Recent Blood Transfusion	Y N	Low Blood Pressure	Y N	Venereal Disease	Y N	HIV+/AIDS	Y N
Scarlet Fever	Y N	Lung Disease	Y N	Epilepsy or Seizures	Y N	Fainting or Dizziness	Y N	Diabetes	Y N
Rheumatic Fever*	Y N	Breathing Problem	Y N	Excessive Thirst	Y N	Genital Herpes	Y N	Hay Fever	Y N
Artificial Heart Valve*	Y N	Shortness of Breath	Y N	Hypoglycemia	Y N	Drug Addiction	Y N	Leukemia	Y N
Heart Pace Maker*	Y N	Frequent Cough	Y N	Liver Disease	Y N	Radiation TreatmentS	Y N	Cold Sores	Y N
Heart Surgery	Y N	Kidney Problems	Y N	Hepatitis A, B or C	Y N	Fever Blisters	Y N		
Blood Disease	Y N	Sinus Trouble	Y N	Night Sweats	Y N	Convulsions	Y N		

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? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by Doctor _____ **Date** _____ **BP** _____

History Review and Significant Findings _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	REVIEWED BY
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____

Our purpose is to provide you high quality dentistry at a reasonable fee. We will provide you care in pleasant surroundings with professional and efficient staff. We thank those of you who have referred their friends and family to our office – it is the highest form of praise. It is because of you, our patients that we are here. Thank you for choosing our office.

In order to better serve you, please understand and observe the following...

- ✓ As a courtesy to our patients, we can verify and file your insurance. We cannot, however, guarantee payment. We suggest that you read your policy manual pertaining to your dental coverage. Many insurance companies have stipulations, such as usual and customary fees, limitations on procedures, limits to the amount paid per procedure, deductibles, co-payments, etc. This information will be listed in your policy manual. You are responsible for all amounts not covered. We have an agreement with you and not with your insurance company for payment. Please be aware of this and plan to make payments accordingly. In the event of denial or non-payment (within 60 days) from your insurance company, this account will become your responsibility.

- ✓ To help keep the cost of Dentistry down, and to continue to provide quality care to our valued patients, we now only accept payment in full, the day of treatment.

- ✓ We will assume that you may have had difficulty getting numb in the past, fear the dentist and/or may have had poor dental experiences. Fortunately, this in the PAST and we will do everything possible TODAY to listen, be gentle and treat you as family. Your past experiences with the dentist are not an indication of what to expect today in our hands.

- ✓ Once you are numb, the treatment will be painless or we will stop immediately and make any needed adjustments.

- ✓ To the greatest extent possible, please remain calm and relaxed during injections and treatment. If you need a break, the doctor will stop. Achieving the best clinical results depends in large part on your cooperation and holding as still as possible while you are being served.

- ✓ We have music, blankets, pillows and other such amenities. Please let us know what you need.

- ✓ Please be respectful of others in the office, including patients as well as the staff (be aware of the tone of your voice, volume and language).

- ✓ If you are feeling anxious and would like laughing gas, please let us know. If you would prefer IV sedation, we can refer you.

- ✓ Once you are taken into the treatment rooms, please remain seated. Do not touch the equipment. Both you and the equipment risk injury if touched inappropriately.

- ✓ You will be provided a post treatment care packet with follow-up instructions.

- ✓ If we can be of service in any way, please do not hesitate to ask.

_____ _____

Signature Date