CONFIDENTIAL PATIENT INFORMATION

The following information is needed in order to better serve you. Please complete all questions. If you need help, please ask our front desk staff. PLEASE PRINT.

Today's Date: _____

Name: _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Birth Date: _____ Marital Status: M S W D Referred by: _____

E-mail address: _____

Your Employer: _____ Occupation: _____

Work Number: _____ Cell Phone; _____ Other: _____

Your SS#:_____

Do You Have Dental Insurance? Y N Policy Holders name: _____

Policy Holders Date of Birth: _____ Policy Holders SS#_____

Insurance Company: _____ Plan/Group #:_____

Spouse or Parents Name: _____ Spouse Employer: _____

Spouse SS#:_____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that dental insurance policies are an arrangement between an insurance carried and myself and that I am personally responsible for payment of any and all services covered or non- covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patients Signature: _____ Date: _____

Guardian's Signature (For Minors):_____ Date: _____

Date of Last Dental Visit: _____

Any Concerns About Your Teeth You Would Like For Dr. Vang To Address Today? _____

_____

Are You Currently Taking Any Medications (If Yes, Please List All) _____

_____

Patient Name:_____ Date:_____

Health problems that you may have, or medication that you may be taking, could have an important relationship with the dentistry you will receive.

Please answer the following questions:

Are you under a physician's care now? YES/NO

Physicians name _____ Phone Number_____

Have you ever been hospitalized or had a major operation? YES/NO If yes _____

Have you ever had a serious head or neck injury? YES/NO

Do you take, or have you ever 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 Nursing Taking Oral Contraceptives

Are you allergic to any of the following?

Asprin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Local Anesthetics

Do you have, or have had, any of the following? Please Circle.

AIDS/HIV Positive	Cortisone Medicine	Hepatitis A B C	Recent Weight Loss
Anemia	Diabetes	Herpes	Renal Dialysis
Angina/Chest Pain	Drug Addiction	High Blood Pressure	Rheumatic Fever
Arthritis/Gout	Emphysema	High Cholesterol	Scarlet Fever
Artificial Heart Valve	Excessive Bleeding	Hives/Rash	Shingles
Artificial Joint	Fainting/Dizziness	Hypoglycemia	Sickle Cell Disease
Asthma	Frequent Cough	Irregular Heartbeat	Sinus Trouble
Blood Disease	Frequent Headaches	Kidney Problems	Stomach/Intestional
Blood Transfusion	Glaucoma	Leukemia	Stroke
Breathing Problems	Hay Fever	Liver Disease	Swelling of Limbs
Cancer	Heart Attack	Lung Disease	Thyroid Disease
Chemotherapy	Heart Murmur	Osteoporosis	Tuberculosis
Cold Sores/Fever Blisters	Heart Pacemaker	Pain in Jaw Joints	Tumors
Congenital Heart Disorder	Heart Disease	Psychiatric Care	Ulcers
Convulsions/Seizures	Hemophilia	Radiation Treatment	Venereal Disease

OTHER: _____