Healthy Smile Dentistry

(951)246-8242

Name _____ ☐ **Male** ☐ **Female**

Last First MI

Address_____

Street Apt City Zip

Telephone (Home)_____ (CELL)_____ SS#_____

Birth Date ___/____/____ Driver's License # _____ State issue ___ EMAIL_____

Primary Dental Insurance	**Secondary Dental Insurance**
_____	_____
Last First MI	Last First MI
_____	_____
Street City State Zip	Street City State Zip
_____	_____
Birthdate Relationship to Patient	Birthdate Relationship to Patient
_____	_____
Employer Dental Ins. Comp	Employer Dental Insurance Comp
_____	_____
Subscriber# Group#	Subscriber# Group#

We can bill certain dental procedures to your Medical insurance

Primary Medical Insurance	**Secondary Medical Insurance**
_____	_____
Last First MI	Last First MI
_____	_____
Street City State Zip	Street City State Zip
_____	_____
Birthdate Relationship to Patient	Birthdate Relationship to Patient
_____	_____
Subscriber# Group#	Subscriber# Group#

Person to contact in case of emergency:

Name:_____ Tel: _____

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 the third party payors and/other health professionals

X_____

Patient or Responsible Party **Date**

NAME_____ **Date**_____

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 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? _____ Yes No

Do you ever have clicking, popping, or discomfort in the jaw joint?_____ Yes No

Do you smoke or chew tobacco? _____ Yes No

Has your past experience in a dental office always positive?_____ Yes No

Name of previous dentist (optional): _____ Yes No

Date of last full mouth Xray (18 small xray or Panoramic) _____ Yes No

Medical History

Are you under a physician's care now? Why?_____Who?_____ Phone#_____ Yes No

Have you ever been or recently 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? What? _____ Yes No

Women (Please check): ☐Pregnant/ Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptive Yes No

Are you allergic to any medication or substance? Please check box below _____Yes No

☐ Penicillin ☐ Codeine ☐ Latex ☐ Metal ☐ Peanuts Other _____Yes No

Do you now have or have you ever had any of the following? Please circle

Heart Trouble Yes No	Sickle Cell anemia Yes No	Renal Dialysis Yes No	Hepatitis A,B,C Yes No	Arthritis/Gout Yes No
Heart Attack/Failure Yes No	Excessive Bleeding Yes No	Thyroid problem Yes No	Venereal disease Yes No	Cortizone Shot Yes No
Heart surgery Yes No	Shortness of Breath Yes No	Parathyroid issue Yes No	HIV/AIDS Yes No	Cancer Yes No
Heart pace maker Yes No	Tuberculosis Yes No	Excessive thirst Yes No	Psychiatric problem Yes No	Leukemia Yes No
Mitral Valve prolapsed Yes No	Pneumonia Yes No	Hypoglycemia Yes No	Epilepsy/Seizures Yes No	Radiation/Chemo Yes No
High blood pressure Yes No	Asthma Yes No	Liver disease Yes No	Drug Addiction Yes No	Artificial joint Yes No
Low blood pressure Yes No	Kidney problem Yes No	Diabetes Yes No		
Bruise easily Yes No				

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? _____

X _____ Patient/Parent or Guardian Date _____

Reviewed by Doctor _____ Date_____