REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date____

SS#____

Patient Name____________________________________

Address____

City__________________________State_______Zip_______

Sex ☐M ☐F

Age_________ Birth Date________

☐Married ☐Widowed
☐Single ☐Minor
☐Separated ☐Divorced

Primary Physician_________________________________

Phone____________________ Last Visit Date___________

Specialist Physician_______________________________

Phone____________________ Last Visit Date___________

Occupation______________________________________

Whom may we thank for referring you?_______________

____

Acknowledgement of Receipt of Notice of Privacy Policies

I,________________, have received a copy of Nguyen Dental Group and it's Associates Notice of Privacy Policies. I understand Nguyen Dental Group and it's Associates may use my health care information and may disclose such information for treatment payment, and health care operations.

____Printed Name

_____________________________ Signature & Date________

2 DENTAL INSURANCE

Who is financially responsible for this account?

_________________________SS#_____________DOB_______

Relationship to Patient______________________________

Insurance Co.___________________________________

Group#____

Insurer's Employer_______________________________

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber's Name_______________________________

Birth Date________________ SS#____________________

Relationship to Patient______________________________

Insurance Co.___________________________________

Group #____

Insurance Assignment
I certify that I, and/or my dependents(s), have insurance coverage

with_____________________________and assign directly to
Name of insurance company(ies)

Dr. Simon H. Nguyen Dental Group, Inc all insurance benefits, if any, otherwise payable to me for services rendered.

Financial and Personal Health Information
I understand that I am financially responsible for all charges incurred during treatment. I further understand that any insurance contract is between my insurance carrier and myself and Nguyen Dental Group and it's Associates is not part of that contract. As a courtesy to our valued patients we will submit your insurance forms initially. If problems occur with insurance portion of your obligation, the balance in full will become due in 30 days. We will provide information to help you deal with your carrier. I understand that finance charges will begin 60 days from date of service if the balance is not paid in full. I authorize the use of my signature on all insurance submissions.

____
Signature of Patient, Parent, Guardian or Personal Representative

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

______________________ ______________________
Date Relationship to Patient

3 PHONE NUMBERS

Home (______)__________________Work (______)__________________Ext _____ Cell Phone (______)__________________

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 Phone (______)_________________________________ Work Phone (______)__________________________________

4 HEALTH HISTORY UPDATE

To be updated at your future dental visits

Date Of Visit	Changes To Health History / Medication	Detail Changes Initials
1.________________________	YES______ NO______	________________________
2.________________________	YES______ NO______	________________________
3.________________________	YES______ NO______	________________________

5 DENTAL HISTORY

Reason for today's visit________________________________
Former Dentist____
City/State____
Date of last dental visit________________________________
Date of last dental X-rays______________________________

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bleeding Gums	☐Yes	☐No
Blisters on lips or mouth	☐Yes	☐No
Chewing/Tobacco use	☐Yes	☐No
Chew on one side of mouth	☐Yes	☐No
Cigarette, pipe, or cigar smoking	☐Yes	☐No
Clicking or popping jaw	☐Yes	☐No
Dry Mouth	☐Yes	☐No
Grinding Teeth	☐Yes	☐No
Gums swollen or tender	☐Yes	☐No
Jaw pain or tiredness	☐Yes	☐No
Periodontal Treatment	☐Yes	☐No
Sore or growths in your mouth	☐Yes	☐No

How often do you floss?________________________________
How often do you brush?________________________________

Have you ever received a local anesthetic?	☐Yes	☐No
A General Anesthetic?	☐Yes	☐No
Any Anesthetic Problems?	☐Yes	☐No

6 HEALTH HISTORY

Place a mark on "yes" or "no" to indicate if you have had any of the of the following:

CARDIOVASCULAR

CAD (angina, heart attack)	☐Yes	☐No
Heart Failure (weak heart)	☐Yes	☐No
High Blood Pressure	☐Yes	☐No
Low Blood Pressure	☐Yes	☐No
Arrhythmias (irregular beat)	☐Yes	☐No
Congenital Heart Defect	☐Yes	☐No
Congenital Heart Lesions	☐Yes	☐No
Valve Disease or Murmur	☐Yes	☐No
Artificial Heart Valve	☐Yes	☐No
Endocarditis (Heart Infection)	☐Yes	☐No
Stroke or TIA	☐Yes	☐No
Blood Cell Disorder	☐Yes	☐No
Bleeding abnormally with Extractions or Surgery	☐Yes	☐No
Circulatory Problems	☐Yes	☐No
Fainting or Dizziness	☐Yes	☐No
Mitral Valve Prolapse	☐Yes	☐No
Pacemaker	☐Yes	☐No

NERVOUS SYSTEM

Seizures/Epilepsy	☐Yes	☐No
Depression/Panic Attacks	☐Yes	☐No
Psychosis or Mania	☐Yes	☐No
Multiple Sclerosis	☐Yes	☐No
Headaches/Migraine	☐Yes	☐No
Substance Abuse	☐Yes	☐No
Physical/mentally Impaired	☐Yes	☐No
Nervous Problems	☐Yes	☐No
Psychiatric Care	☐Yes	☐No

INFECTIONS

Hepatitis Type_________	☐Yes	☐No
HIV/AIDS	☐Yes	☐No
Tuberculosis	☐Yes	☐No
Blood Disease	☐Yes	☐No
Herpes	☐Yes	☐No
Rheumatic Fever	☐Yes	☐No
Scarlet Fever	☐Yes	☐No
Skin Rash	☐Yes	☐No
Emphysema	☐Yes	☐No
Venereal Disease	☐Yes	☐No

RESPIRATORY

COPD	☐Yes	☐No
Emphysema	☐Yes	☐No
Chronic Bronchitis	☐Yes	☐No
Asthma	☐Yes	☐No
Sinus/Hay Fever	☐Yes	☐No
Cough,Persistant/Bloody	☐Yes	☐No
Respiratory Disease	☐Yes	☐No
Shortness of breath	☐Yes	☐No
Obstructive Sleep	☐Yes	☐No

MISCELLANEOUS

Cancer	☐Yes	☐No
Joint Replacements	☐Yes	☐No
Organ Transplant	☐Yes	☐No
Glaucoma	☐Yes	☐No
Arthritis/Rheumatism	☐Yes	☐No
Back Problems	☐Yes	☐No
Cortisone Treatments	☐Yes	☐No
Chemotherapy/Radiation	☐Yes	☐No
Special Diet	☐Yes	☐No
Jaw Pain	☐Yes	☐No
Radiation Treatment	☐Yes	☐No
Respiratory Disease	☐Yes	☐No
Rheumatic Fever	☐Yes	☐No
Scarlet Fever	☐Yes	☐No
Shortness of Breath	☐Yes	☐No
Sinus Trouble	☐Yes	☐No
Skin Rash	☐Yes	☐No
Special Diet	☐Yes	☐No
Stroke	☐Yes	☐No
Swollen Feet or Ankles	☐Yes	☐No
Swollen Neck Glands	☐Yes	☐No
Thyroid Problems	☐Yes	☐No
Tonsillitis	☐Yes	☐No
Tuberculosis	☐Yes	☐No
Tumor or growth on head or neck	☐Yes	☐No
Weight Loss (unexplained)	☐Yes	☐No

ENDOCRINE

Thyroid Disorder	☐Yes	☐No
Diabetes Mellitus	☐Yes	☐No
Immune Disorder	☐Yes	☐No
Pregnant (Due Date:______)	☐Yes	☐No
Breast-feeding	☐Yes	☐No

EXCRETORY

Liver Disorder	☐Yes	☐No
Kidney Disorder	☐Yes	☐No
Bladder Disorder	☐Yes	☐No
Ulcers or GERD	☐Yes	☐No
Intestinal Problems	☐Yes	☐No
Anemia	☐Yes	☐No
Jaundice	☐Yes	☐No

Other Medical Problems: ____________________
____
____
____
____
____
____

MEDICATIONS

List all medications you are currently taking, the correlating diagnosis and any non-prescription products as well.______________________________
____

Pharmacy Name______________________Phone (___)_____________

ALLERGIES

List Allergies to medications, foods, or any other substance:

☐Aspirin ☐Local Anesthetic ☐Barbiturates (Sleeping pills)

☐Penicillin ☐Codeine ☐Sulfa ☐Iodine ☐Latex

☐ other sheet ____

Printed Name____________________________________ Signature____________________________________ Date____________