Welcome! Thank you for selecting our dental health care team. We strive to provide the best possible dental care. If you need assistance completing this form, please ask. We'll be happy to help you.

ABOUT YOU

Today's Date: ______/_____/_______

Patient Name: ________________________________
Last First MI

What you prefer to be called: ________________________

Birthdate: ____/_____/____ SSN# ________________

Mailing Address: ________________________________

____
City State Zip

Home Phone #: ________________________________

Work Phone #: ________________________ Ext:______

Mobile Phone #: ________________________________

E-mail Address: ________________________________

Referred By: ________________________________

Employer: ____________________ How Long: ________

Employer's Address: ________________________________

____
City State Zip

Occupation: ________________________________

Status: Minor Single Married Divorced Separated Widowed

Spouse's Name: ________________________________

Do you have children? Yes No How Many? _______

ACCOUNT INFORMATION

Person ultimately responsible for account

Name: ________________________________

Relation to Patient: ________________________________

Billing Address: ________________________________

____
City State Zip

Driver's License #: ________________________________

Work Phone #: ________________________________

Payment Method: m Cash m Check m Credit Card

____
Credit Card # Expiration

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company. __________Initials

INSURANCE INFORMATION

Primary Dental Insurance

Company Name: ________________________________

Address: ________________________________

____
City State Zip

Phone #: ________________________________

Group, Plan or Policy #: ________________________

Insured's SSN #: ________________________________

Relationship to Patient: ________________________

Insured's Date of Birth: ______/______/__________

Insured's Employer: ________________________

Secondary Dental Insurance

Company Name: ________________________________

Address: ________________________________

____
City State Zip

Phone #: ________________________________

Insured's SSN #: ________________________________

Group, Plan or Policy # ________________________

Insured's Name: ________________________________

Relation to Patient: ________________________

Insured's Date of Birth: ______/______/__________

Insured's Employer: ________________________

IN EVENT OF EMERGENCY

Who should we contact?

Name:

____

Relation to Patient: ________________________

Home Phone #: ________________________

Work Phone#: ________________________

Other Phone #'s: ________________________

Your Medical Dr:

____

M.D.'s Phone #: ________________________

PLEASE CONTINUE ON BACK O

DENTAL INFORMATION

Reason for today's visit: Exam Emergency Consultation Second Opinion Smile Analysis Whitening Other

Are you in pain? No Yes If yes, indicate location: Upper Right, Upper Left, Lower Right, Lower Left

Please indicate by circling any of the following problems:

Discomfort, clicking or popping in jaw	Lost/Broken Fillings	Stained Teeth
Red, swollen or bleeding gums	Teeth grinding	Locking Jaw
Sensitive tooth, teeth, gums	Ringing in ears	Bad breath
Blisters/sores in or around the mouth	Broken/chipped tooth or bridgework	
Ill-fitting partial or full denture	Other ______________________	

Do you require pre-medication? Yes If yes, what medication? ______________________ No Don't know

Previous Dentist: ____
Name Area Code Phone #

Last dental exam: _____/_____/_____ Last dental x-rays: _____/_____/_____

How many times a day do you brush your teeth? ______ How many times a week do you floss your teeth? ________

What type of toothbrush bristles do you use? Soft Medium Hard Electric toothbrush

MEDICAL HISTORY

Please inform our staff of the medications you are currently taking.

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack/Stroke	Y N Thyroid Problems	Y N Cancer/Tumors	Y N Cosmetic Surgery
Y N Heart Surgery/Pacemaker	Y N Kidney Problems	Y N Shingles	Y N X-ray or Cobalt Treatment
Y N Heart Murmur	Y N Liver Problems	Y N Hepatitis	Y N Chemotherapy
Y N Rheumatic Fever	Y N Respiratory Problems	Y N HIV+/AIDS/ARC	Y N Asthma
Y N Mitral Valve Prolapse	Y N Sinus Problems	Y N Arthritis/Rheumatism	Y N Difficulty Breathing
Y N Artificial Valves	Y N Stomach Problems/Ulcers	Y N Artificial Bones/Joints	Y N Diabetes/Hypoglycemia
Y N Heart Disease	Y N Psychiatric Problems	Y N Emphysema	Y N Leukemia
Y N Congenital Heart Defect	Y N Venereal Disease	Y N Fainting/Seizures/Epilepsy	Y N Anemia
Y N Chest Pains	Y N Alcohol/Drug Abuse	Y N Severe/Frequent Headaches	Y N High/Low Blood Pressure
Y N Scarlet Fever	Y N Tuberculosis (TB)	Y N Frequent Neck Pain	Y N Bleeding Problems
Y N Nervousness	Y N Jaw Problems TMJ?TMD	Y N Back Problems	Y N Glaucoma

Please list any other medical condition(s) you have or have ever had: ______________________________________

____

Are you allergic to or have you had a reaction to any of the following?
Latex Penicillin / Amoxicillin Tetracycline Aspirin Dental Anesthesia
Other: ____

Do you use tobacco? No Yes/How used? ________________How often?___________ For how long? ________yrs.

Please rate your general health from 1-10 (Best): __________ Do you wear contact lenses? Yes No

For Women: Are you taking oral contraceptives? Yes No Are you/could you be pregnant? No Yes/How long _____wks.
Are you nursing? Yes No

All Patients: PLEASE REMEMBER TO INFORM OUR OFFICE OF ANY FUTURE CHANGE IN YOUR MEDICAL HISTORY

By signing this form I understand and agree to the following office policies of Queanh Phan, D.M.D. II, PLLC, and James C. Dee, D.M.D. We require payment in full for all services rendered at the time of visit, unless other financial arrangements have been made. If account is not paid within 90 days of the date of service, the patient is responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting the account.

I hereby give my consent to Queanh Phan, D.M.D., II, PLLC and James C. Dee, D.M.D., MAGD, to use my dental photographs, slides, videos, or any other image, with or without my name, for educational purposes and in the use of promoting esthetic dentistry. I have completed this form truthfully, and understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to my child or me during the period of such dental care, to third party payers/ health practioners. I understand that my dental insurance carrier may pay less than the actual bill for my services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: ____ Date:____________________