COMPLETE DENTAL CARE

Tuyet Huynh, DDS

Dental Registration & Contact Info

Patient Information

Date_____

Patient _____
LAST FIRST MI Mr/Mrs/Ms/Dr

Home Address: _____
APT/CONDO #

_____
CITY STATE ZIP CODE

Sex: ☐M ☐F Birth Date: ____/____/___ Age_____

☐Single ☐Married ☐Divorced
☐Widowed ☐Separated

Patient SS#: _____

Occupation:_____

Employer: _____

Employer Address: _____
SUITE #

_____
CITY STATE ZIP CODE

Work #: (___)_____ DL#: _____

Whom may we thank for referring you? _____

_____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Company _____

Group # _____

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber's Name _____

Birth Date: ____/____/___ SS # _____/_____/_____

Relationship to Patient _____

Insurance Co. _____ _____

Group # _____

ASSIGNMENT AND RELEASE:

I, the undersigned, certify that I (or my dependent) have insurance coverage with: _____
And assign directly to Dr. Tuyet Huynh all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____
Relationship Date

IN CASE OF EMERGENCY, CONTACT

(Specify someone who does not live in your household)

Name: _____ Relationship: _____
LAST FIRST MI Mr/Mrs/Ms/Dr

Home Phone: (_____) _____ Work / Cell Phone: (_____)_____

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PATIENT DENTAL & HEALTH HISTORY

Dental History

Reason for today's visit_____

Former Dentist_____City/State_____

Date of last dental visit_____Date of last dental X-rays_____

Check (√) to indicate if you have had any of the following:

□ Bad breath
□ Bleeding gums
□ Clicking or popping of jaw
□ Food collection between teeth
□ Grinding teeth
□ Loosed teeth or broken fillings
□ Periodontal treatment
□ Sensitivity to cold
□ Sensitivity to hot
□ Sensitivity to sweet
□ Sensitivity when biting
□ Sores/ growths in your mouth

How often do you floss?_____How often do you brush?_____

Medical History

Physician's Name_____Date of last visit_____

Check (√) to indicate if you have had any of the following:

□ Abnormal Bleeding
□ AIDS
□ Anemia
□ Arthritis, Rheumatism
□ Artificial Heart Valve
□ Artificial Joints
□ Asthma
□ Back Problem
□ Blood Disease
□ Cancer
□ Chemical Dependency
□ Chemotherapy
□ Circulatory Problems
□ Congenital Heart Lesions
□ Cortisone Treatment
□ Cough
□ Diabetes
□ Emphysema
□ Epilepsy
□ Fainting or Dizziness
□ Glaucoma
□ Headaches
□ Heart Murmur
□ Heart Problems
□ Hepatitis: Type_____
□ Herpes
□ High Blood Pressure
□ Jaundice
□ Kidney Disease
□ Liver Disease
□ Low Blood Pressure
□ Mitral Valve Prolapsed
□ Nervous Problems
□ Psychiatric Care
□ Radiation Treatment
□ Respiratory Disease
□ Rheumatic Fever
□ Scarlet Fever
□ Shortness of Breath
□ Sinus Trouble
□ Smoking
□ Skin Rash
□ Stroke
□ Swelling of Feet
□ Swollen Neck Gland
□ Thyroid Problems
□ Tonsillitis
□ Tuberculosis
□ Ulcer
□ Venereal Disease
□ Weight Loss, unexplained

For Women: Are you taking birth control pills? _____Name of medicine:_____
Are you Pregnant?_____If yes, weeks #:_____Due date: _____Are you nursing?_____

Medications

List medications you are currently taking:

_____

_____

Pharmacy Name:_____

Pharmacy Phone #:_____

Allergies

Check (√) to indicate allergies:

□ Codeine
□ Iodine
□ Latex
□ Aspirins
□ Other
□ Penicillin
□ Local Anesthetic
□ Tetracycline
□ None

_____

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in confidentiality, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature: Date: