PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: ______________________ Date of birth: __________ Sex: ______ Age: _____

Home address: ______________________ City: __________ State: _____ Zip: __________

Billing address (if different): ______________________ City: __________ State: _____ Zip: __________

Home phone: __________ Cell: __________ E-mail: __________ Driver's license #: __________ State: _____

SS #: __________ Employer/Occupation: __________ Bus. Phone: __________

Spouse's name & phone #: ______________________ Emergency phone # (other than spouse): __________

Primary dental insurance: ______________________ Group #: __________

Secondary dental insurance: ______________________ Group #: __________

Subscriber's name: ______________________ Date of birth: __________ SS #: __________

Name of your medical doctor: ______________________ Date of last visit to medical doctor: __________

Name of previous dentist: ______________________ Date of last visit to dentist: __________

Referred to us by: ______________________ ______________________

DENTAL HEALTH HISTORY

	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty in chewing your food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you ever noticed slow-healing sores in or about your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sours?	☐	☐
Sweets?	☐	☐
Do you take fluoride supplements?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Do you prefer to save your teeth?	☐	☐
Do you want complete dental care?	☐	☐

	Yes	No
How often do you brush? __________		
How often do you floss? __________		
Does your jaw make noise so that it bothers you or others?	☐	☐
Do you clench or grind your jaws frequently?	☐	☐
Do your jaws ever feel tired?	☐	☐
Does your jaw get stuck so that you can't open freely?	☐	☐
Does it hurt when you chew or open wide to take a bite?	☐	☐
Do you have earaches or pain in front of the ears?	☐	☐
Do you have any jaw symptoms or headaches upon awaking in the morning?	☐	☐
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	☐	☐
Do you find jaw pain or discomfort extremely frustrating or depressing?	☐	☐
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	☐	☐
Do you have a temporomandibular (jaw) disorder (TMD)?	☐	☐
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you had a blow to the jaw (trauma)?	☐	☐
Are you a habitual gum chewer or pipe smoker?	☐	☐

MEDICAL HEALTH HISTORY:

Do you have, or have you had, any of the following?

	Yes	No
Heart Problems	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
Blood pressure problem	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Blood Problems	☐	☐
Easy bruising	☐	☐
Frequent nosebleeds	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Ever require a blood transfusion?	☐	☐
Allergy Problems	☐	☐
Hay fever	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Taking allergy medication	☐	☐
Asthma	☐	☐
Intestinal Problems	☐	☐
Ulcers	☐	☐
Weight gain or loss	☐	☐
Special diet	☐	☐
Constipation/Diarrhea	☐	☐
Kidney or bladder problems	☐	☐
Bone or Joint Problems	☐	☐
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement (e.g., total hip, pins, or implants)	☐	☐
Fainting Spells, Seizures, or Epilepsy	☐	☐
Stroke(s)	☐	☐
Frequent or severe headaches	☐	☐
Thyroid problems	☐	☐
Persistent cough or swollen glands	☐	☐
Premedications required by physician	☐	☐
Cancer/Tumor	☐	☐

Are you allergic, or have you reacted adversely, to any of the following?

	Yes	No
Local anesthetics ("Novocaine")	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐

Other ____________________

Notes: ____________________

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____________________ Date: __________

	Yes	No
Diabetes	☐	☐
Urinate more than 6 times a day	☐	☐
Thirsty or mouth is dry much of the time	☐	☐
Family history of diabetes	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Do you drink alcohol?	☐	☐
If so, how much? ____________		
Do you smoke?	☐	☐
If so, how much? ____________		
Hepatitis, jaundice, or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV-positive/AIDS	☐	☐
Glaucoma	☐	☐
Do you wear contact lenses?	☐	☐
History of head injury?	☐	☐
Epilepsy or other neurological disease?	☐	☐
History of alcohol or drug abuse?	☐	☐

Do you have any disease, condition, or problem not listed previously that you feel we should know about?
If so, please describe: ____________________

During the past 12 months, have you taken any of the following?

	Yes	No
Antibiotics or sulfa drugs	☐	☐
Anticoagulants (e.g., Coumadin)	☐	☐
High blood pressure medicine	☐	☐
Tranquilizers	☐	☐
Insulin, Orinase, or similar drug	☐	☐
Aspirin	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐
Cortisone (steroids)	☐	☐
Natural remedies	☐	☐
Nonprescription drug/supplements	☐	☐

Other ____________________

____

Women	**Yes**	**No**
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant?	☐	☐
If so, expected delivery date: ____________		
Are you nursing?	☐	☐
Have you reached menopause?	☐	☐
If so, do you have any symptoms? ____________		

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Notes: ____________________

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Patient/Parent Signature: ____________________

Dentist Initial: ____________________

ADEN DENTAL

Welcome to the practice of Dr. Thi Nguyen. It is our desire to provide you with the highest quality dental care in a pleasant and relaxing atmosphere. We will provide a thorough explanation of recommended treatment. It is our experience that patients want to know exactly why dental treatment is necessary prior to treatment. We believe that service to our patients is best when there is mutual cooperation and understanding.

DENTAL INSURANCE

We honor most dental insurances. However, several insurance plans require treatment to be performed only by a member dentist. If this applies to your dental coverage, you should receive a list of member dentists from your insurance company. Any questions concerning coverage may be discussed with our financial coordinator.

As a courtesy to our patients, we will obtain benefit information, attempt to verify eligibility and submit insurance claims. No guarantee is made for any estimated insurance benefits and the patient is financially fully responsible should insurance benefits be less than anticipated. Dental coverage is an agreement that the patient/policy holder has made with the insurance company, mostly through an employer. Your insurance company is responsible to you. We will notify you of any balances not paid by your insurance company. Sixty days following patient notification, any unpaid balance will begin to incur interest charges at the rate of 1.5% per month (18% annually) with a $3.00 minimum service charge. Any returned checks will incur a $25.00 charge.

Signing below authorizes payment directly to Aden Dental for dental benefits, otherwise made payable to you by your insurance company. If there are any questions regarding this, please do not hesitate to ask.

AUTHORIZATION TO RELEASE DENTAL INFORMATION

Signing below authorizes Dr. Thi Nguyen to release any information regarding diagnosis and records of treatment rendered to you or your dependent to third party payers (your insurance company) and/or health practitioners (i.e. specialists for referrals).

PAYMENT OPTIONS

1. We ask that you cover your portion of fees **at the time you receive treatment**. You may pay by cash, credit or debit card.
2. Monthly payment plans are also available through Care Credit.

WE WOULD ALSO LIKE YOU TO KNOW

We appreciate a minimum of 48 business hours notice if you cannot make your reserved appointment time. **We reserve the right to charge a $75.00 per scheduled hour for failed appointments or cancellations with less than 48 hours notice.** Thank you!

Patient Signature____ Date___________

My Documents/Chart/Office Policy

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting an Aden Dental staff member.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used a disclosed, and how you can access your information.

By my signing below I acknowledge receipt of the Notice of Privacy Practices.

______________________________________ ____________________________
Patient or legally authorized individual signature   Date   Time

______________________________________ ____________________________
Printed name (*if signed on behalf of the patient*)   Relationship
(Parent, legal guardian, etc.)

I ______________________________ give Aden Dental my permission to speak with ______________________________ regarding my treatment/upcoming appointments.

I ______________________________ give Aden Dental my permission to leave messages regarding upcoming appointments and treatment on **my home phone**

my cell phone   **my work phone**   **my email address.**

This form will be retained in your dental record

Last Update:___/___/___   Initials:________