ENHANCED SMILES

ALEX HD. PHAM D.D.S., P.A

PATIENT HEALTH HISTORY

PATIENT INFORMATION

Patient Name: (First)____________________(MI)___________(Last)________________________Today's Date_______________

Patient's Birthday_________________ SSN: ____________________ Email: ____________________________________

Address ____ City____________________ State _____ Zip code ______

Marital Status: _____Single _____Married _____Separated _____Divorced _____Widowed

Driver's License # _____________________________________ State __________ Exp. Date ______________________________

If Child, Name of Parents or Guardian ____

Phone (Home) ____________________ (Work) _________________________ (Cell) _____________________________________

Whom May We Thank For Referring You ____

Your preferred method of contact? ______Phone _______Text _______Email

DENTAL INSURANCE INFORMATION

Name of Policy Holder (Subscriber)____ Relationship to Patient __________________

Subscriber's Date of Birth ________________________________ Subscriber's SSN _____________________________

Dental Insurance Co. ____________________________________ Group No. ________________ Policy/ID # _________________

Ins. Co. Address ____ City______________________ State _____ Zip code _________

Name of Employer________________________________ Work Phone ___________________

Employer Address ____ City_______________________ State _____ Zip code ______

Do You Have Any Additional Dental Insurance? ☐YES ☐NO If Yes, Complete The Following

Name of Policy Holder (Subscriber)____ Relationship to Patient __________________

Subscriber's Date of Birth ________________________________ Subscriber's SSN _____________________________

Dental Insurance Co. ____________________________________ Group No. ________________ Policy/ID # _________________

Ins. Co. Address ____ City______________________ State _____ Zip code _________

Name of Employer____ Work Phone ___________________

Employer Address ____ City_____________________ State _____ Zip code _________

MEDICAL HISTORY

Check the appropriate box,YES or NO

Yes	No	Condition
☐	☐	Anemia / Blood Disease
☐	☐	Arthritis
☐	☐	Asthma / Hay Fever
☐	☐	Blood Pressure / High
☐	☐	Blood Pressure / Low
☐	☐	Cancer / Tx / X-ray
☐	☐	Diabetes
☐	☐	Epilepsy / Seizures
☐	☐	Fainting / Nervous
☐	☐	Glaucoma
☐	☐	Heart Murmur
☐	☐	Heart Trouble
☐	☐	Hepatitis / Liver Disease
☐	☐	Herpes / Virus
☐	☐	HIV Positive / AIDS
☐	☐	Joint Replacement
☐	☐	Migraine Headaches
☐	☐	Mitral Valve Prolapse
☐	☐	Neck / Head Pain
☐	☐	Osteoporosis
☐	☐	Pace Maker
☐	☐	Pregnant
☐	☐	Rheumatic Fever
☐	☐	Sleep Apnea
☐	☐	Stroke
☐	☐	TB / Lung Disease
☐	☐	TMJ / Clicking Joint
☐	☐	Venereal Disease
☐	☐	__________________

Allergic to:

Yes	No	Allergy
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Local Anesthesia
☐	☐	Penicillin
☐	☐	Sedative. / Tranq.
☐	☐	__________________
☐	☐	__________________
☐	☐	__________________

Over Please

☐ ☐ Cardiovascular disease (heart attack, angina, coronary insufficient, coronary occlusion, arteriosclerosis)

☐ ☐ Are you taking blood thinner? ____________________

☐ ☐ Are you taking birth control pills? ____________________

☐ ☐ Are you using tobacco products? If yes, what kind and what amount?____________________

☐ ☐ Do you need to be **pre-medicated**? For what? ____________________

☐ ☐ Do you have any other health problems not listed above? ____________________

☐ ☐ Have you had any **surgery** or been **hospitalized** in the past 3 years?
If Yes, Please explain____________________

____

My physician is ____________________ Office Phone:____________________

Taking medications ☐ Yes ☐ No If yes, please list ____________________

____

____

DENTAL HISTORY

Date of Last Dental Treatment ____________________ Date Previous X-ray ____________________

Previous Dentist ____________________

What is your main concern with your teeth and mouth? ____________________

____

____

Would you like to improve your smile? ☐ Yes ☐ No

Are you interested in whitening your teeth? ☐ Yes ☐ No

Are you interested in straightening your teeth? ☐ Yes ☐ No

Do you get up with sore jaws or headaches? ☐ Yes ☐ No

Comments ____________________

____

____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnoses and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist of dental group insurance benefits otherwise payable to me. I understand my insurance carrier may pay less than the actual bill for services. I agree to pay any and all charges not covered by my dental insurance. I agree to pay co-payment at the times that services are rendered on my behalf or my dependents.

____________________ ____________________
(Signature of patient or parent of minor) (Date)

ACKOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____________________, received information of this office's Notice of Privacy Practices
(Please print name)

____________________ ____________________
(Signature) (Date)