# Welcome

John H.T. Nguyen, D.M.D.,P.A.

## About You

First Name: _____Middle Initial: __ Last Name:_____Prefer to be called:_____

Birth Date: __/__/____Social Security #:_____Home Phone :_____Cell Phone:_____

Email Address:_____ Single___Married___Divorced___Widowed___Seperated___

Address: _____ City: _____ State: _____ Zip: _____

To whom may we thank for referring you?_____

Employer: _____ Occupation: _____ Work Phone: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

### Person Responsible for Account if Other than Patient

Name: _____ Relation to Patient: _____ Phone: _____

Date of Birth: _____ Social Security #: _____ Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

## Emergency Contact

Name: _____ Relation to you: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

## Spouse Information

His/Her Name: _____ Birth Date: ___/___/___ Social Security #:_____

Employer: _____ Work Phone#: (___)_____ Ext:____ Driver's License #: _____

## Insurance Information

Primary Insurance Company: _____ Policy Holder: _____

Policy Holder's Date of Birth: _____ Policy Holder's Social Security #: _____

Policy Holder's ID #: _____ Group #: _____ Insurance Company Phone: _____

Insurance Company Address: _____ City: _____ State: ____ Zip: _____

Secondary Insurance Company: _____ Policy Holder: _____

Policy Holder's Date of Birth: _____Policy Holder's Social Security #: _____

Policy Holder's ID #: _____ Group #: _____ Insurance Company Phone: _____

Insurance Company Address: _____ City: _____ State: ____ Zip: _____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

## DENTAL HISTORY

What concerns you most? _____

Are you having discomfort at this time? _____ What is the discomfort? _____

Previous/Present Dentist (Circle One):_____ When was your last visit? _____ Did you have X-Rays? _____

Are your teeth sensitive to: heat? _____ cold? _____ sweets? _____ sour? _____ pressure? _____

Have you ever had your teeth straightened? _____ If so, when? _____ Did you have traditional braces? _____

How often do you brush your teeth? _____ How often do you use dental floss? _____

Do you have bleeding gums? _____ Have you ever had gum treatment? _____ When? _____

Do you grind or clench your teeth? _____ Do you hear popping or clicking noises when you chew? _____

Do you have any pain around either of your ears? _____ Any swelling or lumps in your mouth? _____

Do you have any fear of dental treatment? _____

How do you feel about the appearance of your teeth?_____

_____

## MEDICAL HISTORY

Are you currently under a Physicians care? _____ Physician's Name _____

Physician's Address _____ Physician's Phone _____

Do you or have you experienced any of the following? (Please circle Y/N)

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Y | N | Abnormal Bleeding | Y | N | Diabetes | Y | N | Hemophilia | Y | N | Psychiatric Problems |
| Y | N | Alcohol Abuse | Y | N | Difficulty Breathing | Y | N | Hepatitis | Y | N | Radiation Treatment |
| Y | N | Anemia | Y | N | Drug Abuse | Y | N | Herpes | Y | N | Respiratory Problems |
| Y | N | Artificial Bones/Joints | Y | N | Emphysema | Y | N | High Blood Pressure | Y | N | Seizures |
| Y | N | Artifical Valves | Y | N | Epilepsy | Y | N | HIV+/AIDS | Y | N | Sinus Problems |
| Y | N | Asthma | Y | N | Fainting Spells | Y | N | HPV | Y | N | Steroid Problems |
| Y | N | Bisphosphonate taken | Y | N | Fever Blisters | Y | N | Kidney Problems | Y | N | Stroke |
| Y | N | Cancer | Y | N | Fibromylagia | Y | N | Liver Disease | Y | N | Thyroid Problems |
| Y | N | Chemotherapy | Y | N | Glaucoma | Y | N | Low Blood Pressure | Y | N | Tobacco Use (Smoke/Chew) |
| Y | N | Chest Pain | Y | N | Headaches | Y | N | Lupus | Y | N | Tonsilitis |
| Y | N | Colitis | Y | N | Heart Attack | Y | N | Mitral Valve Prolapse | Y | N | Tuberculosis (TB) |
| Y | N | Congentital Heart Defect | Y | N | Heart Murmur | Y | N | Pacemaker | Y | N | Ulcers |
| Y | N | Convulsions | Y | N | Heart Surgery | Y | N | Pain in Jaw Joints | Y | N | Venereal Disease |

Please list any serious medical condition(s) that you have experienced._____

_____

Are you allergic to any of the following? (Please circle Y/N)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Y | N | Aspirin | Y | N | Erythromycin | Y | N | Sedatives |
| Y | N | Barbiturates | Y | N | Jewelry/Metals | Y | N | Sulfa Drugs |
| Y | N | Codeine | Y | N | Latex | Y | N | Tetracycline |
| Y | N | Dental Anesthetics | Y | N | Penicillin | Y | N | Other |

Have you taken antibiotics prior to dental procedures in the past?(Circle one) Yes / No

Please list additional drugs/materials that cause allergic reactions: _____

Please list any and all medications you are currently taking: _____

**For Women:** Are you taking birth control pills? _____ Are you pregnant? _____ Week #: _____ Are you nursing? _____

## AUTHORIZATION

I affirm that the information I have given is correct to the best of my knowledge. All information herein will be held in the strictest confidence and it is my responsibility to inform Winter Springs Dentistry of any changes in my medical status. I authorize dental staff to perform the necessary dental services may need, including x-rays, photographs, study models, or any aids deemed appropriate to make a thorough diagnosis of my dental needs.

Signature: _____ Date: _____

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