HAVRE DE GRACE DENTAL

Christopher Nguyen, DMD
363 Green Street, Havre de Grace, MD 21078
Email: Havredegracedental@gmail.com Phone: 410-939-1177

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name _____ Preferred name _____ Birthdate_____

If minor, parents names _____ Cell Phone _____ Home phone _____

Email: _____

Mailing address _____ City _____State _____ Zip _____

Employer: _____ Occupation _____

Spouse's name _____ Spouse's employer _____ ❑ Unmarried

Whom may we thank for referring you to our office? _____

Please tell us about your any hobbies you may have? _____

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: _____ Dental Insurance Co._____ Member ID #_____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _____ Member ID # _____

Spouse's birthday _____ Social Security number _____

MEDICAL HEALTH HISTORY

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

- ❑ Cancer or tumor
- ❑ Heart attack
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism or Drug Abuse
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you have any disease, condition, or problem not listed above?

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

- ❑ Latex materials
- ❑ Penicillin or other antibiotics: _____
- ❑ Local anesthetics ("Novocaine")
- ❑ Codeine or other narcotics:_____
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ *Other*:_____

Do you need to be PREMEDICATED for treatment?: ____

Are you taking any of the following? ***Please list medications***

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners): _____
- ❑ Antibiotics or sulfa drugs: _____
- ❑ High blood pressure medicine: _____
- ❑ Antidepressants or tranquilizers: _____
- ❑ Insulin, or other diabetic drug: _____
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids:_____
- ❑ Osteoporosis (bone density) medicine:_____
- ❑ ***Other medications***:_____
  _____

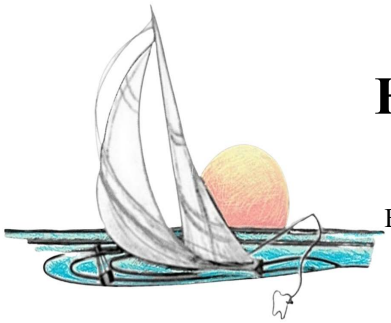
❑ Do you smoke or use chewing tobacco? ❑ yes ❑ no

Women:

- ❑ Pregnant? ❑ yes ❑ no
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Name of your physician: _____Phone: _____

Signature of patient (or parent) _____ Date: _____



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Questions about your Dental Health:

1. Are you having any discomfort at this time? _____
2. When was you last dental exam?_____
3. How often do you brush your teeth?_____
4. How often do you floss?_____
5. Do you grind or clench your teeth?_____
6. Are you aware of any tenderness in your head, neck, and mouth area?_____
7. Are you a mouth breather? _____
8. Do you experience frequent headaches?_____
9. Are there specific dental health issues that you would like to discuss today?_____

_____