WELCOME TO OUR OFFICE

In order to render optimum health service, it is necessary to become acquainted with the vital information related to each patient. All information is kept strictly confidential. Although some questions may seem unimportant at the moment, they may be vital in case of emergency

PLEASE ANSWER EVERY QUESTION ON BOTH SIDES

Personal information Today's Date__________________

Patient's Name ____________________ Date of Birth (dd/mm/yyyy) _________ Age ___

Address _________________________ Home Phone ___________________________

City _________________________ Mobile Phone __________________________

Postal Code _______________________ Sex _______ Marital Status _____________

Occupation ________________________ Medical Doctor _______________________

Name of Employer __________________ Email _________________________________

Name of person responsible for this account (if under the age of 16) ______________________

Do you have dental insurance? ☐ Yes ☐ No

Actual Subscriber's Name____________________ Birthdate (dd/mm/yyyy) ______________

Insurance Company Name ____

Policy No. ______________________________ Certificate No. ______________________

General Dentist _____________________________ Referred by __________________________

Emergency Contact ______________________ Phone No. ___________________________

MEDICAL HISTORY

	YES	NO
1. Have you had a recent illness, operation, been hospitalized or under the care of a physician?	☐	☐
If yes, explain ____		
2. Are you presently taking any medicines, drugs, or pills?	☐	☐
If yes, explain ____		

3. Do you have or have you ever had any of the following? (Circle)

Rheumatic Fever	Kidney Disease	Thyroid Disease
Heart Trouble	Diabetes	Lung Disease
High Blood Pressure	Epilepsy	Asthma
Heart Murmur	Radiation or Chemo Therapy	Blood Disorders / Anemia
Psychiatric Problems	Gastrointestinal Disease	Anxiety / Panic Attack
Neurological Disorders	HIV / Immunosuppression	Cancer
Liver Disease (Jaundice, Hepatitis)	Fibromyalgia	Sinusitis Arthritis

Other ____

	YES	NO
4. Do you have any allergies to any foods, medication, material e.g. latex, antibiotics?	☐	☐
If yes, explain ____		
5. Have you ever had freezing (local anaesthetic) in your mouth?	☐	☐
Any ill effects from it? ____		

MEDICAL HISTORY CONT.

	YES	NO
6. Have you reacted adversely to any of the following?		
Penicillin or other antibiotics?	☐	☐
Sedatives, calium, or sleeping pills?	☐	☐
Aspirin, Ibuprofen?	☐	☐
Codeine?	☐	☐
Other? ____		
7. Do you bleed abnormally, bruise easily, have fainted before or have experienced shortness of breath?	☐	☐
8. Is there anything that the dentist should know regarding your medical history that has not been mentioned?	☐	☐
If yes, explain ____		
9. To the best of your knowledge, are you in good health?	☐	☐
WOMEN: Are you pregnant?	☐	☐
If yes, in what trimester are you in? ____________________		

DENTAL HISTORY

	YES	NO
1. Have you ever been a patient here?		
2. Are you having pain? Yes☐ No☐ Hot Cold Bite Touch		
3. Is there swelling or pressure?	☐	☐
4. Do you have or have you had panic attacks / anxiety attacks at any dental appointments?	☐	☐
5. Do you gag easily at dental appointments?	☐	☐
6. Are you claustrophobic?	☐	☐
7. What is our present dental problem? ____________________________		
Did you receive a prescription for your dental problem?	☐	☐

OFFICE POLICY (Please Read)

1. Regarding insurance: All professional services are CHARGED DIRECTLY TO THE PATIENT and PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF BILLS ON THEIR ACCOUNTS. We will prepare any necessary forms or reports to help collect your benefits from insurance companies.
2. Please help us to maintain the operations of our office on sound principles so that we may assure you and other patients uninterrupted treatment. Remember that once you have made an appointment, this time is **reserved for you**; therefore, at least **48 hours NOTICE** must be given if cancellation is absolutely necessary. If notice is not given, a cancellation fee may be charged.
3. Office policy is that services are paid for at each visit as they are performed.
4. I have read and understand the collection and use of information for Dr. Ngo's and Delle Donne's office in order to process insurance claims, reports and letters.
5. **Patient's / Guardian's signature** ____

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   - Aspirin, Ibuprofen? ☐ ☐
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