Welcome to Village Center Dentistry

Patient Information

Today's Date: _____

Name: _____

Birthdate: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Occupation _____

Employer/School _____

Whom may we thank for referring you?

_____

Phone Number & Email

Home: _____ **Work:** _____

Mobile: _____

Email: _____

Emergency Contact

Emergency Contact: _____

Relationship: _____

Mobile: _____

Home_____ Work _____

Dental Insurance

Subscriber's Name: _____

Birthdate: _____

Insurance Co. _____

Subscriber's I.D. # :_____

Subscriber's Group #: _____

ASSIGNMENT AND RELEASE

I certify that I and/or my dependents have insurance coverage with _____ and assign directly to Dr. Linda Hoang all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named dentist may use my health care information and may disclose such information to above named company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

_____

Responsible Party Signature

_____ _____

Print Name **Date**

Dental History

Reason for todays visit _____ **Are you interested in whitening?** □ **Yes** □ **No**

Date of last dental visit _____ **Date of last dental X-rays** _____

Please check the box to indicate if you have any of the following:

☐ Bad Breath	☐ Chew on one side of mouth	☐ Gums swollen or tender	☐ Mouth pain, brushing
☐ Bleeding gum	☐ Cigarette, pipe or cigar smoking	☐ Jaw pain or tiredness	☐ Periodontal Treatment
☐ Blister on lips or mouth	☐ Clicking or popping jaw	☐ Lip or cheek biting	☐ Sensitivity to cold
☐ Burning sensation on tongue	☐ Dry mouth	☐ Loose teeth or broken	☐ Sensitivity to heat
	☐ Grinding teeth	☐ Fillings	☐ Sensitivity to sweets

How often do you floss? _____ How often do you brush daily? _____

Health History

Name of Physician _____ Physician's Phone _____

When was the last time you saw your physician? _____

Please state the reason of your last medical visit _____

Are you now under the care of a physician? ☐ Yes ☐ No If yes, please explain. _____