# Patient Registration Patient:

## Redhawk Family Dentistry Hang-Nga Vu, D.D.S.

Patient Information		Date:				
Chart ID:						
First Name:	Last Name:					
Address:						
City:			Z	Zip:		
Home Phone:						
Cell Phone:						
Email Address:						
Sex: 🔿 Male		Marital Status:	○ Single			
○ Female			O Married			
			O Divorced			
			<ul> <li>Separated</li> </ul>			
			◯ Widowed			
Birth Date:						
SSN:	Driver's License:					
Employment Status: O Full Time			Retired			
Student Status: O Full Time	⊖ Part T	ime				
Primary Insurance Information Name of Insured: Relationship to Patient: O Self Insured SSN:	○ Spouse	-	O Other			
Insured SSN:						
Employer:	Insurance Company:Address:					
Address:		Audress.				
City/St/Zip:		City/St/Zip:				
Secondary Insurance Informati						
Name of Insured:						
Relationship to Patient: O Self	○ Spouse	O Parent	◯ Other			
Insured SSN:		Insured Birth Date:				
Employer:						
Address:		Address:				
City/St/Zip:		City/St/Zip:				

### Medical History Patient:

#### Redhawk Family Dentistry Hang-Nga Vu, D.D.S.

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?       Yes       No       N/A         Have you ever been hospitalized or had a major operation?       Yes       No       N/A         Have you ever had a serious head or neck injury?       Yes       No       N/A         Have you taking any medications, pills, or drugs?       Yes       No       N/A         Do you take, or have you taken, Phen-Fen or Redux?       Yes       No       N/A         Are you on a special diet?       Yes       No       N/A         Women:       Are you       Pregnant/Trying to get pregnant?       Invising?       Taking oral contraceptives?											
Are you allergic	to any of the follow	wing?									
Aspirin	Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other										
Yes No AlDS/ AlDS/ AlDS/ AlDS/ Anapl Anapl Anapl Anapl Anthri Arthri Arthri Arthri Arthri Arthri Arthri Blood Blood Breat C Bruss	nia na ritis/Gout icial Heart Valve icial Joint ma d Disease d Transfusion thing Problem se Easily		0	Yes 000000000000000000000000000000000000	No Genital Her Glaucoma Hay Fever Heart Attac Heart Attac Heart Pace Heart Troul Henophilia Hepatitis A Hepatitis B Herpes High Blood Hives or Ra Hypoglycer	erpes ck/Failure mur e Maker uble/Disease a a 3 or C d Pressure ash	Yes 000000000000000000000000000000000000	No Irregular Heartbeat Kidney Problems Leukemia Liver Disease Low Blood Pressure Lung Disease Mitral Valve Prolapse Pain in Joints Parathyroid Disease Psychiatric Care Radiation Treatments Recent Weight Loss Renal Disease Rheumatic Fever Rheumatism	Yes 000000000000000000000000000000000000	No Scarlet Fever Shingles Sickle Cell Disease Sinus Trouble Spina Bifida Stomach/Intestinal Disease Stroke Swelling of Limbs Thyroid Disease Tonsillitis Tuberculosis Tumors or Growths Ulcers Venereal Disease Yellow Jaundice	
Have you ever had any serious illness not listed above?			0	No 🔿 Ye	es						
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.											

Signature of patient, parent, or guardian

Date

#### Consent:

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any diagnostic aid deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, use medication and further authorize that Doctor choose and employ such assistance as he/she deems fit. I also understand the use of anesthetics, palliative, and antibiotic agent embodies a certain risk. I understand that responsibility for payments of dental services provided in this office for myself or my dependents is mine. Payment is due at the time services are rendered, unless previous arrangements have been made. I further authorize Doctor to investigate my credit standing by means of a credit report when appropriate.