Patient Registration

Patient: _____

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

Patient Information

Date: _____

Chart ID: _____

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Pager: _____

Email Address: _____

Sex: ◯ Male ◯ Female

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____

SSN: _____ Driver's License: _____

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Primary Insurance Information

Name of Insured: _____

Relationship to Patient: ◯ Self ◯ Spouse ◯ Parent ◯ Other

Insured SSN: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

_____ _____

City/St/Zip: _____ City/St/Zip: _____

Secondary Insurance Information

Name of Insured: _____

Relationship to Patient: ◯ Self ◯ Spouse ◯ Parent ◯ Other

Insured SSN: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

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	_____
Are 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	Do you use tobacco? ◯ Yes ◯ No
Are you on a special diet?	◯ Yes	◯ No	◯ N/A	Do you use controlled substances? ◯ Yes ◯ No

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other _____

Do you have, or have you had, the following?

Yes	No		Yes	No		Yes	No		Yes	No		Yes	No	
◯	◯	**AIDS/HIV Positive**	◯	◯	**Chest Pains**	◯	◯	**Frequent Headaches**	◯	◯	**Irregular Heartbeat**	◯	◯	**Scarlet Fever**
◯	◯	**Alzheimer's Disease**	◯	◯	**Cold Sores**	◯	◯	**Genital Herpes**	◯	◯	**Kidney Problems**	◯	◯	**Shingles**
◯	◯	**Anaphylaxis**	◯	◯	**Congenital Heart Disorder**	◯	◯	**Glaucoma**	◯	◯	**Leukemia**	◯	◯	**Sickle Cell Disease**
◯	◯	**Anemia**	◯	◯	**Convulsions**	◯	◯	**Hay Fever**	◯	◯	**Liver Disease**	◯	◯	**Sinus Trouble**
◯	◯	**Angina**	◯	◯	**Cortisone Medicine**	◯	◯	**Heart Attack/Failure**	◯	◯	**Low Blood Pressure**	◯	◯	**Spina Bifida**
◯	◯	**Arthritis/Gout**	◯	◯	**Diabetes**	◯	◯	**Heart Murmur**	◯	◯	**Lung Disease**	◯	◯	**Stomach/Intestinal Disease**
◯	◯	**Artificial Heart Valve**	◯	◯	**Drug Addiction**	◯	◯	**Heart Pace Maker**	◯	◯	**Mitral Valve Prolapse**	◯	◯	**Stroke**
◯	◯	**Artificial Joint**	◯	◯	**Easily Winded**	◯	◯	**Heart Trouble/Disease**	◯	◯	**Pain in Joints**	◯	◯	**Swelling of Limbs**
◯	◯	**Asthma**	◯	◯	**Emphysema**	◯	◯	**Hemophilia**	◯	◯	**Parathyroid Disease**	◯	◯	**Thyroid Disease**
◯	◯	**Blood Disease**	◯	◯	**Epilepsy or Seizures**	◯	◯	**Hepatitis A**	◯	◯	**Psychiatric Care**	◯	◯	**Tonsillitis**
◯	◯	**Blood Transfusion**	◯	◯	**Excessive Bleeding**	◯	◯	**Hepatitis B or C**	◯	◯	**Radiation Treatments**	◯	◯	**Tuberculosis**
◯	◯	**Breathing Problem**	◯	◯	**Excessive Thirst**	◯	◯	**Herpes**	◯	◯	**Recent Weight Loss**	◯	◯	**Tumors or Growths**
◯	◯	**Bruise Easily**	◯	◯	**Fainting Spells**	◯	◯	**High Blood Pressure**	◯	◯	**Renal Disease**	◯	◯	**Ulcers**
◯	◯	**Cancer**	◯	◯	**Frequent Cough**	◯	◯	**Hives or Rash**	◯	◯	**Rheumatic Fever**	◯	◯	**Venereal Disease**
◯	◯	**Chemotherapy**	◯	◯	**Frequent Diarrhea**	◯	◯	**Hypoglycemia**	◯	◯	**Rheumatism**	◯	◯	**Yellow Jaundice**

Have you ever had any serious illness not listed above? ◯ No ◯ Yes _____

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.

Signature _____ Date _____