Dr. Hoang & Staff Would Like to Welcome You!

Where Smiles Here Are Contagious!

For Office Use Only: Date ____/_____/_____ Chart ID: _____ Claim Type:

1. *Tell Us About Our New Patient.* (Please Print Clearly)

First Name: _____ Last Name _____
Middle Initial:_____: Do You Have a Nickname You Prefer To Be Called As? _____

Gender: ☐Male ☐Female **Birthday** M/DD/YY _____/_____/_____
Social Security #: (Strictly Confidential) _____-_____-_____

Martial Status: ☐Minor/Child ☐Single ☐Married ☐Divorced/Separated
Home Address: _____
City: _____, State: _____ Zip_____
Home Phone: ( ) _____-_____; Cell Phone: ( )_____-_____

Employer:_____ Occupation:_____
Work Phone: ( ) _____-_____ Ext:_____

***IF PATIENT IS A MINOR:** Please Fill Out This Portion
Responsible Party: First & Last Name, MI: _____
Social Security #: _____-_____-_____; Birthday: _____/_____/_____

2. *Other Info.*

We Send Out Routine Check Up Reminders to Our Patients. Would You Like to Receive Yours by Email? ☐Yes ☐No; Email Address: _____

How Did You Hear About Us? ☐YellowPages ☐News Paper _____
☐Internet ☐ A Friend or Family Member:_____ _____
☐ Other

3. *Insurance.* * Please Note; We Only Participate With PPO Policies

***** *The following information will be required in order for us to file claims correctly.*
PRIMARY Dental Ins. Name:_____
Policy Holder's: Name _____
SS # _____-_____-_____ DOB**:** _____/_____/_____

Relationship to Patient: ☐Self ☐Spouse ☐Dependent

SECONDARY Dental Ins. Name:_____
Policy Holder's: Name _____
SS # _____-_____-_____ DOB: _____/_____/_____

Relationship to Patient: ☐Self ☐Spouse ☐Dependent

Please Continue on Back

4. *In Case of Emergency……*

Who would you like us to contact? Please provide the following for a friend or relative not living with you:

Name: _____
Home Phone: ( )_____-_____ Work Phone: ( ) _____-_____
Cell Phone: ( )_____-_____Relationship to You: _____

Name: _____
Home Phone: ( )_____-_____ Work Phone: ( ) _____-_____
Cell Phone: ( )_____-_____Relationship to You: _____

5. *Dental History*

What Brings You Into Our Office Today? _____

How Often Do You Floss? ☐Daily ☐Less than 3 Times a Week ☐Not Often ☐Never
How Often Do You Brush? ☐ 2-3 Times Daily ☐Once a Day ☐Sometimes ☐Never

Do You Use Anything in Addition to Brushing and Flossing?
If Yes, what & when_____

Do Your Gums Bleed? ☐Yes ☐No;
Have You Ever Been Told You Have Periodontal (Gum) Disease? ☐Yes ☐No, If Yes, When_____
Are Your Teeth Sensitive to Any of the Following? ☐ Heat ☐Cold ☐Sweet ☐Pressure
Do You Experience Discomfort in Your Jaws (TMJ/TMD)? ☐Yes ☐No, If Yes, When_____
Would You Like Whiter Teeth? ☐Yes ☐No
Are There Things You Would Like to Improve About Your Smile? ☐Yes ☐No

Previous Dentist: Dr._____; Date of Last Visit: _____

6. *Authorization*

I affirm that the information I have given on this form is correct to the best of my knowledge & it is my responsibility to inform this office of any changes in my medical status & any other personal info that would be relevant to my care. I authorize my insurance benefits be paid directly to Binh Hoang DDS, PLC & I understand that I am responsible for the payment of deductibles, co-payments, and any balances not covered by my insurance. I also, authorize Dr. Binh Hoang's Practice to release any information required to process my claims. I understand that payment is due at the time of service, unless other arrangements have been made prior.

_____ _____
Signature Date