

**ENHANCED SMILES**  
**ALEX HD. PHAM D.D.S., P.A**  
**PATIENT HEALTH HISTORY**

**PATIENT INFORMATION**

Patient Name: (First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Patient's Birthday \_\_\_\_\_ SSN: \_\_\_\_\_ Email: \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
 Marital Status: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed  
 Driver's License # \_\_\_\_\_ State \_\_\_\_\_ Exp. Date \_\_\_\_\_  
 If Child, Name of Parents or Guardian \_\_\_\_\_ Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_  
 Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_  
 Whom May We Thank For Referring You \_\_\_\_\_  
 Your preferred method of contact? \_\_\_\_\_ Phone \_\_\_\_\_ Text \_\_\_\_\_ Email \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

Name of Policy Holder (Subscriber) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Subscriber's Date of Birth \_\_\_\_\_ Subscriber's SSN \_\_\_\_\_  
 Dental Insurance Co. \_\_\_\_\_ Group No. \_\_\_\_\_ Policy/ID # \_\_\_\_\_  
 Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
 Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

**Do You Have Any Additional Dental Insurance?  YES  NO If Yes, Complete The Following**

Name of Policy Holder (Subscriber) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Subscriber's Date of Birth \_\_\_\_\_ Subscriber's SSN \_\_\_\_\_  
 Dental Insurance Co. \_\_\_\_\_ Group No. \_\_\_\_\_ Policy/ID # \_\_\_\_\_  
 Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
 Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

**MEDICAL HISTORY**

*Check the appropriate box, YES or NO*

Yes No	Yes No	Yes No	<b>Allergic to:</b>
<input type="checkbox"/> <input type="checkbox"/> Anemia / Blood Disease	<input type="checkbox"/> <input type="checkbox"/> Heart Murmur	<input type="checkbox"/> <input type="checkbox"/> Pace Maker	Yes No
<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Heart Trouble	<input type="checkbox"/> <input type="checkbox"/> Pregnant	<input type="checkbox"/> <input type="checkbox"/> Aspirin
<input type="checkbox"/> <input type="checkbox"/> Asthma / Hay Fever	<input type="checkbox"/> <input type="checkbox"/> Hepatitis / Liver Disease	<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/> Codeine
<input type="checkbox"/> <input type="checkbox"/> Blood Pressure / High	<input type="checkbox"/> <input type="checkbox"/> Herpes / Virus	<input type="checkbox"/> <input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> <input type="checkbox"/> Local Anesthesia
<input type="checkbox"/> <input type="checkbox"/> Blood Pressure / Low	<input type="checkbox"/> <input type="checkbox"/> HIV Positive / AIDS	<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/> Penicillin
<input type="checkbox"/> <input type="checkbox"/> Cancer / Tx / X-ray	<input type="checkbox"/> <input type="checkbox"/> Joint Replacement	<input type="checkbox"/> <input type="checkbox"/> TB / Lung Disease	<input type="checkbox"/> <input type="checkbox"/> Sedative. / Tranq.
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> <input type="checkbox"/> TMJ / Clicking Joint	<input type="checkbox"/> <input type="checkbox"/> _____
<input type="checkbox"/> <input type="checkbox"/> Epilepsy / Seizures	<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease	<input type="checkbox"/> <input type="checkbox"/> _____
<input type="checkbox"/> <input type="checkbox"/> Fainting / Nervous	<input type="checkbox"/> <input type="checkbox"/> Neck / Head Pain	<input type="checkbox"/> <input type="checkbox"/> _____	<input type="checkbox"/> <input type="checkbox"/> _____
<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Osteoporosis		

*Over Please*

- Cardiovascular disease (heart attack, angina, coronary insufficient, coronary occlusion, arteriosclerosis)
- Are you taking blood thinner? \_\_\_\_\_
- Are you taking birth control pills? \_\_\_\_\_
- Are you using tobacco products? If yes, what kind and what amount? \_\_\_\_\_
- Do you need to be **pre-medicated**? For what? \_\_\_\_\_
- Do you have any other health problems not listed above? \_\_\_\_\_
- Have you had any **surgery** or been **hospitalized** in the past 3 years?  
If Yes, Please explain \_\_\_\_\_

My physician is \_\_\_\_\_ Office Phone: \_\_\_\_\_

Taking medications  Yes  No If yes, please list \_\_\_\_\_

## DENTAL HISTORY

Date of Last Dental Treatment \_\_\_\_\_ Date Previous X-ray \_\_\_\_\_

Previous Dentist \_\_\_\_\_

What is your main concern with your teeth and mouth? \_\_\_\_\_

Would you like to improve your smile?  Yes  No

Are you interested in whitening your teeth?  Yes  No

Are you interested in straightening your teeth?  Yes  No

Do you get up with sore jaws or headaches?  Yes  No

Comments \_\_\_\_\_

### AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnoses and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist of dental group insurance benefits otherwise payable to me. I understand my insurance carrier may pay less than the actual bill for services. I agree to pay any and all charges not covered by my dental insurance. I agree to pay co-payment at the times that services are rendered on my behalf or my dependents.

X \_\_\_\_\_  
(Signature of patient or parent of minor) (Date)

### ACKNOWLEDGEMENT OF RECEIPT OF Notice of Privacy Practices, Office Policy, Broken Appointment Policy, Dental Ins. Policy

I, \_\_\_\_\_, received the above information.  
(Please print name)

X \_\_\_\_\_  
(Signature) (Date)