NOVA
DENTAL CENTER
Dr. Binh K. Hoang, DDS

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Novadentalva.com

Patient Information & History

First Name: _________________________ Middle: _____________________ Last Name: ______________________________

Birthday (MM/DD/YYYY): ______________ Gender: _____Male _____Female SSN#: ___________________________

Marital Status: ____ Minor/Child _____Single ____Married ____Divorced/Separated

Email: ____

Home Address: ____

City: _______________________________ State: ______________ Zip: _______________

Home Phone: (______)________________ Cell: (______)_________________ ALT#: (______)_________________

Employer: ____ Occupation: ____________________________

Work Address: ____

Work Phone : (______)_________________ EXT: __________________

Please fill out this portion if ***PATIENT IS A MINOR***

Responsible Party (FIRST, M.I. & LAST NAME): _________________________________ SSN#: ___________________________

Birthday (MM/DD/YYYY): ______________ Relationship to Patient: _____ Parent _____Guardian _____Other

Insurance

Primary Dental Insurance: ____ Group ID#: ______________________________

Policy Holder's Name: _______________________________________ Subscriber ID#: __________________________________

Policy Holder's SSN: ____ Policy Holder's DOB (MM/DD/YYYY): ________________

Relationship to Patient: _____Self ______Spouse ______Dependent

Secondary Dental Insurance: ____ Group ID#: ______________________________

Policy Holder's Name: _______________________________________ Subscriber ID#: __________________________________

Policy Holder's SSN: ____ Policy Holder's DOB (MM/DD/YYYY): ________________

Relationship to Patient: _____Self ______Spouse ______Dependent

Emergency Contact

Just in case we need to contact someone

Name: ____ Relationship to Patient: ____________________________________

Home Phone: (______)________________ Cell: (______)_________________ Work Phone: (______)_____________________

Name: ____ Relationship to Patient: ____________________________________

Home Phone: (______)________________ Cell: (______)_________________ Work Phone: (______)_____________________

Dental History

What brings you into the 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 & and how often? __________________________________

Do your gums bleed? _____ Yes _____ No

Have you ever been told you have *PERIDONTAL (GUM) DISEASE*? _____ Yes _____ No If *YES*, when ______________________

Are your teeth sensitive to any of the following? _____ Heat _____ Cold _____ Sweets _____ 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: ____ Date last seen: _____________________________________

Authorization

I affirm the information I have given on this form is correct to the best of my knowledge and it is my responsibility to inform the Nova Dental Center Team of any changes in my medical status and any other personal information that would be relevant to my care. I authorize the Nova Dental Center to release any information required to process my insurance claims and benefits be paid directly to Dr. Binh K. Hoang DDS, PLC. I understand payment is due at time of service as I am responsible for the payment of deductibles, co-payments, and any balances not covered by my insurance.

Signature: ____ **Date:** ____