W E L C O M E

Trinity Dental

Kevin Bui, D.D.S. and Matthew Orth, D.D.S.

Patient Information

Date _____

Patient Name _____

Address _____

_____

DOB _____ SS# _____

Single Married Other

Phone Numbers (home)_____
(work)_____
(other)_____

Patient employer _____

Whom may we thank for referring you? _____

Have any of your family members been here before?_____

Dental History

Reason for Today's Visit_____

Last Dental visit _____

Check all that apply:

__ Cigarette or cigar smoking
__ Clicking or Popping jaw
__ Orthodontic Treatment
__ Loose teeth/ broken fillings
__ Food collects between teeth
__ Sensitivity to cold or heat
__ Bleeding Gums
__ Dry mouth
__ Periodontal Treatment
__ Grinding teeth
__ Mouth breathing
__ Sensitivity to sweets

How often do you floss?_____

How often do you brush?_____

Medications

List any medications you are currently taking_____

_____

_____

Pharmacy name and number_____

Dental Insurance Information

Subscriber Name_____

Date of Birth_____ SS#_____

Relationship to Patient_____

Insurance Company_____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance with _____ and assign directly to Drs. Bui/Orth all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions

_____
Responsible Party Signature Date

Medical History

Physician's Name:_____Phone #_____
Date of last check-up:_____

__ Arthritis
__ Asthma
__ Thyroid
__ Diabetes
__ Epilepsy
__ Herpes
__ Pacemaker
__ Pregnancy
__ Stroke
__ Hepatitis
__ Artificial Heart Valve/Artificial Joints
__ Bleeding disorders
__ Rheumatic fever
__ Chemical Dependency
__ Heart Murmur
__ High / Low Blood Pressure
__ Mitral Valve Prolapse
__ Psychiatric Care
__ Tuberculosis
__ Cancer / Radiation treatment
__ Other_____

Surgeries:_____

Allergies

__ Aspirin
__ Codeine
__ Penicillin
__ Local Anesthetic
__ Barbiturates
__ Latex
__ Sulfa
__ Other_____

To the best of my knowledge, the information above is complete and accurate.

_____ _____
Signature of person completing form Date Doctor's Initials

Initial BP _____ Pulse _____