9275 E. Stockton Blvd., Suite 200. Elk Grove CA 95624
PH: 916-688-1990—Fax: 916-688-5467
Email: frontdesk@newdentalimages.com
www.newdentalimages.com

Patient Information:

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) ____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____
_____ (City) ____ (State) _____ (Zip Code)

Spouse's Name: _____

Address: _____

Phone #: _____

Email: _____

Emergency Contact Name: _____

Address: _____

Phone #: _____

Email: _____

Patient Name: _____ DOB: _____

Financial Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Driver's License #: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) ____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Primary Dental Insurance

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Patient Name: _____ DOB: _____

Secondary Dental Insurance

Name of Insured: _____ _____ _____
Last First MI

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

_____ _____ _____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ _____ _____
City State Zip Code

Your Chief Dental Complaint today? _____

How often do you brush and floss your teeth? _____

Are you currently wearing Dentures, partials or any removal medical device? _____

Physician Name: _____

Address: _____

Phone: _____

Current/Former Dentist Name: _____

Address: _____

Phone: _____

Patient Name: _____ DOB: _____

Medical History:

☐ ADD/ADDHD	☐ AIDS	☐ Allergies/Hives
☐ Anemia	☐ Anxiety	☐ Arthritis
☐ Aspirin Allergy	☐ Blood Trans	☐ Chest Pain
☐ Chronic Mastoid	☐ Chronic Sinus	☐ Codeine Allergy
☐ Cold Sores/Blisters	☐ Congenital Heart	☐ Coumadin
☐ Diabetes	☐ Down Syndrome	☐ Emphysema
☐ Epilepsy	☐ Fainting	☐ Fen-Phen
☐ Glaucoma	☐ HBP	☐ Heart Surgery
☐ Hemophilia	☐ Hepatitis	☐ Herpes
☐ HIV	☐ Jaundice	☐ Joint Replacement
☐ Kidney Problems	☐ Latex Allergy	☐ Liver Disease
☐ Mental Disorders	☐ MVP	☐ Other
☐ Pacemaker	☐ Penicillin Allergy	☐ Pondimen
☐ Pre-Med	☐ Prozac	☐ Psychiatric Treatmen
☐ Radiation Treatment	☐ Redux	☐ Rheumatic Fever
☐ Schizophrenia	☐ Seizures	☐ Stroke
☐ Sulfa Allergy	☐ Sulphur	☐ Thyroid
☐ Tuberculosis	☐ Tumors	☐ Venereal Disease

Are you **ALLERGIC** to any Medications? [ ] NO [ ] YES

If YES—Please List All Medications:

_____

_____

Have you ever had to **Pre-Medicated** for any treatment? [ ] NO [ ] YES

If YES—Please List All Medications and Conditions: _____

_____

Patient Name: _____ DOB: _____

Are there any surgeries or medical treatment including?

Currently: _____

Pending: _____

Past: _____

Is there a possibility that you are or maybe PREGNANT (Female only)? [ ] NO [ ] YES

If Yes---How many weeks? _____

Please- List all the Current Medication that you are taking and Reasons:

I UNDERSTAND THAT THE INFORMATION GIVEN HERE IS, TO THE BEST OF MY KNOWLEDGE and CORRECT. I ALSO UNDERSTAND THIS INFORMATION WILL BE HELD IN STRICT CONFIDENCE; AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS. WITH MY INFORMED CONSENT, I AUTHORIZED THE DENTAL STAFF TO PERFORM ANY NECESSARY DENTAL SERVICE (S) INDICATED DURING DIAGNOSIS AND TREATMENT. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE DUE. IF I HAVE INSURANCE, I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE "DR. VAN DANG DDS (NEW DENTAL IMAGES)". I ALSO AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION REQUIRED FOR PAYMENT TO BE MADE. FINALLY, I UNDERSTAND THAT AFTER 60 DAYS A SERVICE CHARGE OF 18% ANNUALLY WILL BE CHARGED MONTHLY ON ANY UNPAID BALANCE. I AUTHORIZE THE USE OF PHOTOGRAPHS OF ME TAKEN FOR THE PURPOSE OF PATIENT EDUCATION.

☐ By checking this box, I acknowledge that I have read this statement and fully understand and agree to the contents.

Patient's Signature: _____ Date: _____