Hope Ann Nguyen DDS, APC
9450 Cuyamaca St., #101
Santee, CA 92071

Patient Information

Date _____/_____/_____

What is the reason for your visit today?

_____

Child's Name _____ **Nick Name**_____
Child's SS# _____ **Main Email** _____
Sex M F Age_____ **Birthdate**_____ **School** _____ **Grade** _____
Name and Ages of Brothers _____
Name and Ages of Sisters _____
Child's Address _____
Residence Phone _____
Nearest living relative not living with child _____
Phone Number_____ **Address** _____

Mother's/Father's Name _____	**Father's/Mother's Name**_____
Date of Birth_____	**Date of Birth** _____
Social Security #_____	**Social Security #**_____
Driver's License#_____	**Driver's License#**_____
Occupation_____	**Occupation**_____
Address_____	**Address**_____
_____	_____
Home Phone # _____	**Home Phone #**_____
Cell Phone #_____	**Cell Phone #**_____
Employer_____	**Employer**_____
Work Phone_____	**Work**
Phone_____	
Employer's Address_____	**Employer's Address**_____
_____	_____

Father's Dental Insurance Co._____**Group #**_____
Dental Insurance Billing Address_____
Mother's Dental Insurance Co._____**Group #**_____
Dental Insurance Billing Address_____
Dual Insurance? Y / N Child's Primary Ins _____ **Secondary Ins**_____
Whom may we thank for referring you to our office?_____

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Medical History

Child's Physician_____City_____
Phone Number_____Date of last physical exam_____
Is your child presently under the care of a physician for any medical problem? Y / N
If so, for what problem?_____
Is your child taking any medications? _____
Has there been any changes to their health within the past year? Y / N
Does your child bruise easily? Y / N
Is your child allergic to any medications? Y / N _____
Does your child have a history of allergies Y / N _____
Has your child ever been hospitalized or had surgery? Y / N _____
Has your child ever had a blood transfusion? Y / N _____
Is your child emotionally disturbed, developmentally delayed, handicapped, or have a learning disability? Y /N _____

Please indicate if your child has had a history of the following:

Heart Trouble/Murmur Y / N	Epilepsy Y / N	Learning Problems Y / N
Rheumatic Fever Y / N	Kidney Disease Y / N	Behavior Problems Y / N
Diabetes Y / N	Hepatitis or Jaundice Y / N	Ulcers or Stomach Pain Y / N
Tuberculosis Y / N	Stroke Y / N	Seizure Disorder Y / N
Anemia Y / N	Head or Neck Pain Y / N	Neurological Problems Y / N
Arthritis/Joint Disease Y / N	Glaucoma Y / N	HIV Virus or AIDS Y / N
Asthma Y / N	Skin Orders, Rashes, Hives Y / N	Hearing Problems Y / N
Blood Disorder Y / N	Respiratory Problems Y / N	Sight Problems Y / N
Bone Disorder Y / N	Bleeding Problems Y / N	Trauma Y / N
Cancer Y / N	Mental Retardation Y / N	Convulsions Y / N
Congenital birth defects Y / N	Developmental Delays Y / N	Thyroid Problems Y / N

Any other conditions or problems that the doctor should be aware of?_____
_____.

Dental History

Is this your child's first dental visit?_____
Previous Dentist_____ City_____ Date of last visit_____
Has your child had an unfavorable experience at another office? Y / N
How do you think your child will act towards the dentist? _____
Times per day your child brushes their teeth _____ Dental Floss Used_____ Is Fluoride taken in any form_____
Does your child have a history of the following? Please Circle. Finger sucking, Lip Sucking, Nail Biting, Pacifier How old was your child when they discontinued bottle use or nursing? _____
Does your child have a problem with their bite? Y / N
I hereby state that the above information is true and correct
Relation to child_____ Print Name _____
Signature_____ Date_____