



Hope Ann Nguyen DDS, APC
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 Santee, CA 92071

PATIENT INFORMATION

This confidential information is of great value in helping us to better understand and treat your child.

REASON FOR VISIT / CHIEF COMPLAINT _____

Date

SS# Main Email

Child's Name Nickname SEX M F

Age Birthday School Grade

Name & age of brothers

Name & age of sisters

Child's Address City Zip

Residence Phone

Nearest relative not living with child Relative Phone

Relative Address City Zip

Father's Name _____	Mother's Name _____
Father's Date of Birth _____	Mothers's Date of Birth _____
Father's Social Security # _____	Mother's Social Security # _____
Driver's License# _____	Driver's License# _____
Occupation _____	Occupation _____
Father's Address _____	Mother's Address _____
Home Phone # _____	Home Phone # _____
Cell Phone # _____	Cell Phone # _____
Father's Employer _____	Mother's 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? YES NO Child's Primary Dental Insurance _____ Secondary Insurance _____

Whom may we thank for referring you to our office? _____

PLEASE COMPLETE REVERSE SIDE