Victor Truong, DDS
6200 Center Street, Suite I & J,
Clayton, CA 94517

THE GROVE
FAMILY DENTISTRY

Tel: (925) 219- 3939
Fax: (925) 270- 0615
www.TheGroveFamilyDentistry.com

Our goal is to help you achieve and maintain your maximum oral health, a smile you are proud to show off. The better we communicate, the better we are able to care for you and together achieve this goal. Please fill out this form as completely as possible. We want to make sure we are well informed about your medical history, dental history, and any other factors that might affect your dental health and treatment. Together we can work to achieve your goals.

ABOUT YOU

How did you hear about us? _____

Name (First, Middle, Last):_____

Preferred Name: _____ Gender: Male / Female

Birthdate:_____ Age:_____ SS#:_____

☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Minor

Address: _____

City:_____ State:_____ Zip: _____

Check your preferred contact # ☐Home Phone: _____

☐Cellphone: _____ ☐Work Phone:_____

Email Address:_____ Ok to email? YES / NO

Best time of the day to reach you? _____

Employer:_____ Occupation: _____

Emergency Contact (Specify someone who does not live in your household).

Name:_____ Relationship:_____

Emergency Contact Phone Number: _____

DENTAL INSURANCE

Person Responsible for Account: _____

Do you have dental insurance coverage? Yes / No

Primary Insurance

Insurance Subscriber's Name: _____

Subscriber's Birthdate: _____ SS#:_____

Dental Insurance Co. name & phone: _____

Subscriber ID #: _____ Group#: _____

Employer:_____ Occupation: _____

Subscriber's phone#:_____ Relationship:_____

Do you have a Secondary Insurance? Yes / No

Insurance Subscriber's Name: _____

Subscriber's Birthdate: _____ SS#:_____

Dental Insurance Co. name & phone: _____

Subscriber ID #: _____ Group#: _____

Employer:_____ Occupation: _____

Subscriber's phone#:_____ Relationship:_____

DENTAL HISTORY

Why have you come to our office today? _____ Are you in pain? Yes No If yes, for how long? _____

Previous Dentist: _____ Phone: _____ Last dentist visit: _____

What was done?: _____ Date of Last Cleaning:_____ Date of last X-rays: _____

Have you ever been told that you require antibiotics before dental treatment? Yes No

Do you have or have you ever had any of the following conditions, ailments, or treatment? Circle "Yes" or "No"

Bad Breath	Yes	No	Food Stuck Between Teeth	Yes	No	Pain Around Ear	Yes	No
Bleeding Gums	Yes	No	Pain When Brushing	Yes	No	Clenching or Grinding Teeth	Yes	No
Broken Fillings/ Teeth	Yes	No	Swollen or Painful Gums	Yes	No	Sensitivity to Cold/ hot / sweet	Yes	No
Sores or Growths in Mouth	Yes	No	Jaw Pain	Yes	No	Chew on Only One Side	Yes	No
Lip or Cheek Biting	Yes	No	Clicking or Popping of Jaw	Yes	No	Loose Teeth	Yes	No
Snoring	Yes	No	Dry Mouth	Yes	No	Braces	Yes	No

Have you ever had a difficult problem/ bad experience associated with any previous dental work? **Yes** **No**

If yes, please explain why: _____

_____

How would you classify your current dental health? **Excellent** **Good** **Fair** **Poor** **Very Poor**

On a scale of 1-10, how would you rate your smile (10 being the best)? _____

Would you like whiter teeth? **Yes** **No** Would you like straighter teeth? **Yes** **No**

How many times a day do you brush/floss: _____ / _____ What type of bristles does your toothbrush have? **Soft** **Medium** **Hard**

HEALTH HISTORY

Are you currently under the care/supervision of a physician? Yes / No If yes, please explain why: _____

_____

Physician's Name: _____ Phone: _____

Are you currently taking any prescription medications? Yes / No If yes, please list medications with correlating diagnosis: _____

_____

Are you currently taking any oral contraceptives (WOMEN ONLY)? Yes / No Are you pregnant? Yes / No Are you nursing? Yes / No

Are you **allergic** to any of the following? (circle all that apply): Penicillin Clindamycin Ibuprofen/Motrin Aspirin Vicodin Percocet Codeine

Latex Barbiturates/Sleeping Pills Dental Anesthetics (ex. Lidocaine) Augmentin Erythromycin Tetracycline Jewelry/Metals Sulfa

Please list any other allergies: _____

_____

Have you ever had any of the following medical conditions? Circle "Yes" or "No"

Abnormal Bleeding	Yes	NO	Fainting Spells	Yes	NO	Mitral Valve Prolapse	Yes	NO
Alcohol or Drug Abuse	Yes	NO	Frequent Headaches	Yes	NO	Pacemaker	Yes	NO
Anemia	Yes	NO	Glaucoma	Yes	NO	Psychiatric Care	Yes	NO
Arthritis	Yes	NO	Hay Fever	Yes	NO	Radiation Treatment	Yes	NO
Artificial Joints/ Heart Valves	Yes	NO	Heart Attack	Yes	NO	Rheumatic/Scarlet Fever	Yes	NO
Asthma	Yes	NO	Heart Murmur	Yes	NO	Seizures	Yes	NO
Blood Transfusion	Yes	NO	Heart Surgery	Yes	NO	Shingles	Yes	NO
Cancer/Chemotherapy	Yes	NO	Hemophilia	Yes	NO	Sickle Cell Disease/Trait	Yes	NO
Colitis	Yes	NO	Hepatitis	Yes	NO	Sinus Problems	Yes	NO
Congenital Heart Disease	Yes	NO	Herpes/ Fever Blisters	Yes	NO	Stroke	Yes	NO
Diabetes	Yes	NO	High / Low Blood Pressure	Yes	NO	Tobacco dependency	Yes	NO
Difficulty Breathing	Yes	NO	HIV or Aids	Yes	NO	Thyroid Problems	Yes	NO
Emphysema	Yes	NO	Kidney Problems	Yes	NO	Tuberculosis	Yes	NO
Epilepsy	Yes	NO	Liver Disease	Yes	NO	Venereal Disease	Yes	NO

Please explain any serious medical conditions you have ever had: _____

_____

I acknowledge that the information I give in this form is correct to the best of my knowledge, and I understand that this information will be held in the strictest confidence. I also understand that is my responsibility to inform this office of any changes in my insurance or medical status. I understand that I am required to pay for any dental services provided. I hereby authorize payment directly to this doctor otherwise payable to me, in the situation where my insurance plan does not pay for a portion or a procedure, I acknowledge that I am responsible to pay in full for that procedure. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment.

_____ _____ _____ _____

Patient's Signature (Parent or Guardian) Date Reviewing Dentist's Signature Date

Date : _____ Changes: _____ Patient Signature: _____ Reviewed by: _____

Date : _____ Changes: _____ Patient Signature: _____ Reviewed by: _____

Date : _____ Changes: _____ Patient Signature: _____ Reviewed by: _____

Date : _____ Changes: _____ Patient Signature: _____ Reviewed by: _____