



# Health History

## Dental History

Reason for today's visit \_\_\_\_\_ Former Dentist: \_\_\_\_\_ Last dental visit: \_\_\_\_\_

**Do you recently have or previously had any of:** Y N

Bad Breath.....

Gum: bleed when you brush your teeth?.....

Periodontal (gum) treatment.....

Blister on lips or mouth.....

Chew on one side of the mouth.....

Food trap areas.....

Grinding teeth .....

Sensitive to hot and cold.....

How often do you brush? \_\_\_\_\_

How often do you floss? \_\_\_\_\_

Do you smoke or use tobacco?.....

**Do you require antibiotics before any of**

**your dental treatment?** .....

**Have you experienced:** Y N

Clicking or popping of the jaw?.....

Pain around joint, ear, side of face?.....

Difficulty in opening or closing the mouth?.....

Are you currently in pain?.....

**Have you ever had difficult problem associated**

**with any previous dental work?** .....

**If yes, please describe:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you like the way your teeth look? .....

Please describe how you would like your teeth to look:

\_\_\_\_\_

\_\_\_\_\_

## Medical History (Please check the box if you have or have had the following)

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Abnormal Bleeding     | <input type="checkbox"/> Congenital Heart defect | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Pace Maker          |
| <input type="checkbox"/> Alcohol Abuse         | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Psychiatric Problem |
| <input type="checkbox"/> Allergy               | <input type="checkbox"/> Difficult Breathing     | <input type="checkbox"/> Hepatitis B           | <input type="checkbox"/> Radiation Therapy   |
| <input type="checkbox"/> Anemia                | <input type="checkbox"/> Emphysema               | <input type="checkbox"/> Hepatitis C           | <input type="checkbox"/> Rheumatic Fever     |
| <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Artificial Joint      | <input type="checkbox"/> Fainting Tendency       | <input type="checkbox"/> HIV + AIDS            | <input type="checkbox"/> Shingles            |
| <input type="checkbox"/> Artificial Valve      | <input type="checkbox"/> Frequent Headache       | <input type="checkbox"/> Joint Replacement     | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Sinus Problems      |
| <input type="checkbox"/> Bruise easily         | <input type="checkbox"/> Hay Fever               | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Cancer / Chemotherapy | <input type="checkbox"/> Heart Attack            | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Thyroid Problems    |
| <input type="checkbox"/> Cholesterol           | <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Colitis               | <input type="checkbox"/> Heart Surgery           | <input type="checkbox"/> Nervous / Anxiety     | <input type="checkbox"/> Venereal Disease    |

**Are you currently under a physician's care?** Y / N. If yes, Physician: \_\_\_\_\_ Tel: \_\_\_\_\_

**List Medication that you are currently taken:** \_\_\_\_\_

## Check any of the following that you are taking or have taken:

\_\_\_ Blood Thinners \_\_\_ Cortisone Drugs \_\_\_ Steroids \_\_\_ Anticoagulants \_\_\_ Tranquilizers \_\_\_ Sedatives

## Are you allergic to any of the following :

\_\_\_ Aspirin \_\_\_ Codein \_\_\_ Pennicillin \_\_\_ Tetracycline

\_\_\_ Dental Anesthesia \_\_\_ Latex / Metals

\_\_\_ Other drugs / Materials: \_\_\_\_\_

## For female only:

1. Are you taking any control pills?  Y  N

2. Are you pregnant?  Y  N if yes, \_\_\_\_\_ weeks

3. Are you nursing?  Y  N

## Treatment Authorization:

I authorize and give consent to perform dental service agreed between doctors and patient and/or parent or guardian to be necessary advisable including the use of anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient / Responsible Party

Relationship to Minor (if applicable)

Dan J. Hoang, DDS, PA

1205 Clear Lake City Blvd., Houston, TX 77062

## Office Policies

Thank you for choosing Dr. Hoang's Dental Practice. We realize that you have a choice in selecting your dental care provider and are honored that you have chosen us. Our goal is to present you with the best solution possible to treat your personal situation, and our entire staff is committed to providing our patients with the highest quality of care possible. In doing so, we would like to provide you with some information regarding our office policies. Please feel free to speak to our business staff if you have any questions.

**INSURANCE** - We currently accept all private care insurance plans. We are also In-Net Work Providers for Aetna, BCBS, Cigna, Delta Premier, Humana, Met-Life, and United Concordia. Dental insurance is intended to cover some, but not all of the cost of your dental care. Most plans include co-insurance. We estimate your portion based on the most up-to-date information we received from your insurance company, but it is ONLY AN ESTIMATE. We will work with you to assure that you receive the maximum benefits to which you are entitled.

We are happy to file your insurance claims as a courtesy. You are responsible to pay, **at the time of service**, any co-pays, deductibles, co-insurances, and any non-covered services. If we are unable to verify your insurance coverage before your appointment, you may either reschedule your appointment or be held responsible for all fees accrued on that particular date of service. If insurance does not pay within 90 days, the service charges will be your responsibility.

**CHANGE OF INSURANCE** - Please remember that it is your responsibility to inform our office, of any changes in your insurance coverage in advance. Failure to do so could result in services that are rendered to you becoming your financial responsibility.

**PAYMENT** - Please remember that payment is due at the time of service. For your convenience, we accept cash, Debit Cards, Visa, Mastercard, Discover, American Express, CareCredit, and CharseHealth Financing.

**APPOINTMENT** – Our office reserves a specific amount of time exclusively for you. To ensure that all our patients get adequate and efficient service, we reserve your next hygiene appointment after each routine check up and ask that you request your planned treatment appointment in advance. To remind you of your appointment, an **automated service** will email you and/or text your cellular phone in the following manner: **1<sup>st</sup> Reminder by Email:** 2 weeks prior to your appointment, you will receive a reminder email. Please click on the **CONFIRM** button after reviewing your appointment date and time, add to your calendar. Do not reply. If change is necessary, please **CALL** our office immediately; so we can help you reschedule to a different time.

**2<sup>nd</sup> Reminder by Text:** Received 2 days prior to appointment. Please reply to our text with **"C."**

**3<sup>rd</sup> Reminder by Text:** a courtesy reminder 2 hours prior to your appointment for patient with text only.

\* If you do not have a hygiene appointment scheduled in advance, our automated service will remind you of your check up is due or past due via **email only**. We appreciate you providing us with your email address.

**Please notify our office 24 hours prior to your scheduled appointment if change or cancellation is necessary to void a \$35 fee assessed to your account. Emergency is an exception.**

Again, thank you for choosing Dan Hoang, DDS, PA

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Dan J. Hoang, DDS, PA  
1205 Clear Lake City Blvd., Houston, TX 77062

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been informed and understand that my protected health information will be used to:

- Provide and coordinate my treatment in this office or among a number of healthcare providers who may involve directly and indirectly.
- Obtain payment from third-party payers for my dental care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

My signature confirms that I have received a more complete copy of this office's Notice of Privacy Practice.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Patient

Dependent family members also covered by this acknowledgement:

Patient: \_\_\_\_\_

Patient: \_\_\_\_\_

Patient: \_\_\_\_\_

Patient: \_\_\_\_\_

Patient: \_\_\_\_\_

Patient: \_\_\_\_\_

.....  
**FOR OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
  - Communication barriers prohibited obtaining the acknowledgement.
  - An emergency situation prevented us from obtaining acknowledgement.
  - Other (Please specify)
- \_\_\_\_\_