Thanh Tricia Vu D.M.D
806 Marietta Ave., Lancaster, PA 17603

Patient: (Last, First, Middle) _____ Birth Date _____
Address _____City _____State _____ Zip code _____
Home Phone _____Cell Phone _____ Occupation _____
Gender _____ SSN # _____ Marital Status _____
Employer Name _____Work Phone_____
Insurance Company Name _____Insured ID # _____
Insured Name _____ Insured DOB _____
Relationship to Patient _____Insured SSN # _____
Person to Contact in case of emergency _____ Phone _____
Whom may we thank for referring you? _____

HEALTH HISTORY

Date of last physical examination _____
Are you now or have recently been under a physician's care? ☐No ☐ Yes … Explain _____
_____
Name of physician _____ **Address** _____ **Phone** _____
Have you ever been hospitalized or had any serious illness? ☐No ☐Yes ... Explain:_____
_____
Do you smoke or use tobacco products? ☐No ☐Yes...How often?_____

Check ☒ if you have had any of the following:

☐ **AIDS/HIV**	☐ Depression/Mental Disorder	☐ Herpes	☐ **Rheumatic Fever**
☐ Anemia	☐ Diabetes	☐ High Blood Pressure	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Drug/Alcohol Abuse	☐ Jaundice	☐ Shortness of Breath
☐ **Artificial Heart, Valves**	☐ Emphysema	☐ Kidney Disease	☐ Sinus Trouble
☐ Asthma	☐ Epilepsy	☐ Liver Disease	☐ **Stroke**
☐ Back Problems	☐ Fainting or dizziness	☐ Low Blood Pressure	☐ Thyroid Problems
☐ Blood Disease	☐ Glaucoma	☐ **Mitral Valve Prolapsed**	☐ Tuberculosis
☐ Blood Transfusion	☐ Hay Fever	☐ **Pacemaker**	☐ Ulcer
☐ Cancer or Tumor	☐ **Heart Attacks**	☐ **Prosthetic Joint Replacements**	☐ Venereal Disease
☐ Chemotherapy	☐ **Heart Murmur**	☐ Radiation Treatment	
☐ Congenital Heart Lesions	☐ **Hepatitis Type** ☐	☐ Respiratory Disease	

List medications you are currently taking _____
Allergies _____

For Women: Are you pregnant? ☐No ☐Yes Are you nursing? ☐No ☐Yes
Taking birth control pills? ☐No ☐Yes

Is there anything else we should know about your medical history? _____

The above information is accurate and complete to the best of my knowledge and is only to use for my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ Signature: _____

Assignment and Release

I, _____ The undersigned have insurance with _____
Print Name *Name of Insurance Company*

assign directly to Dr. Vu all benefits, if any otherwise payable to me for services rendered.
I hereby authorize the doctor to release all information necessary to secure the payment of benefits.
I authorize the use of signature on all my insurance submissions whether manual or electronic.

Date _____ Signature _____

MINOR/CHILD CONSENT

I, _____ being the parent or guardian of _____
Print Name *Name of minor/child*

do authorize the doctor and dental staff to perform necessary dental services for my child.

Date _____ Signature of insured/guardian _____

FINANCIAL AGREEMENT

I acknowledge that payment is due at time of treatment, unless other arrangements are made.
I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child.
I understand and accept full financial responsibility for all charges whether or not paid by insurance.

Date _____ Signature of insured/guardian _____

OFFICE POLICY

All medical/dental records and X-rays are the properties of this office.
In the event of continuously missed 2 scheduled appointments we reserve the right NOT to reschedule you.
In the event of a returned check an additional amount of $25 for processing will be charged. We cannot accept a personal or business check to replace NSF items. Payment for the amount of the check plus $25 must be paid in cash, cashiers check, or money order. The NSF is charged for any reason such as insufficient funds or closed account.