



WELCOME TO DR. VINH HUYNH'S OFFICE
ORTHODONTICS ACQUAINTANCE CARD/ INFORMACION DEL PACIENTE

PATIENT 'S SECTION/ INFORMACION DEL PACIENTE

NAME/Nombre, SS No./No. de seguro social, Sex/Sexo, Age/ Edad, DOB/Fecha de nacimiento, HOME PHONE/No. de telefono de casa, SPOUSE'S NAME, HOME ADDRESS, SCHOOL, EMPLOYER NAME, HOW DO YOU KNOW ABOUT US, NAME YOUR GENERAL DENTIST, RELATE PATIENT UNDER OUR CARE, NAMES & AGES OF OTHER CHILDREN

IF UNDER 18/ RESPOSIBLE PARTY/ MENOR DE EDAD

FATHER'S NAME, MOTHER'S NAME, HOME ADDRESS, SSN OF FATHER, FATHER'S EMPLOYER, MOTHER'S EMPLOYER

INSURANCE INFORMATION

Dental Ins. Co., Their customer service phone no., Policy Number, Group No. & Employer Name

DENTAL SUBSCRIBERS INFORMATION

First & Last Name, Relationship, SSN, Home Phone, Office Phone, Date of Birth, Other Phone, Time To Call

YES NO, Joint swelling, Bone Disorder, Heart Trouble, Thyroid Problem, Rheumatic Trouble, Diabetes, HIV/AIDS, Anemia, Kidney/Liver Problem, High Blood Pressure, Bleeding Problem, Tuberculosis, Other, Name of the Physicians, Are You Pregnant, Any Injuries to Face, Mouth, Teeth, Thumb, finger, lip sucking, Any missing permanent teeth, Any teeth removed by extraction, Any difficulty in swallowing or Chewing, Any pain or clicking on opening mouth, Allergie/Alergias, Has an Orthodontist Been Consulted Presiously

Patient's attitude toward orthodontic treatment/Cual es su actitud hacia el tratamiento de ortodoncia

Very Motivate/Muy motivado, Will Cooperate if Needed/Va cooperar si nesecita, Not Motivated/No motivado

What would you like to have orthodontic treatment accomplish/Que quiere que se realize con el tratamiento de ortodoncia

Any question(s) please ask for staff/ Si tiene alguna pregunta consulte con la recepcionista

To the best of my knowledge, the above information is complete and correct/ Segun mi leal la informacion que econtestado esta corecta.

Date/Dia, Signature

Signature of Parent or Guardian if Patient is a Minor