



GERMANTOWN
DENTAL VILLAGE

Tuan M. Nhu, DDS

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301-428-3211

Emergency Contact

Emergency Contact Name:

Relationship to Patient:

Phone Number:

Address:

Signature * _____

Dental Radiographs (x-rays)

If you have had dental x-rays taken recently, please forward them to our office prior to your visit!

Have you had dental radiographs (x-rays) taken this year?

☐ Yes ☐ No

Name of Previous Dental Provider's Office: _____

Phone Number of Previous Dental Office: _____

Dental Health

Are there specific dental health issues or concerns you would like to discuss?

Do you have, or have you ever had any of the following dental conditions? Please check all that apply. *

- | | |
|--|--|
| <input type="checkbox"/> None of the above | <input type="checkbox"/> Aching or sensitive teeth |
| <input type="checkbox"/> Areas of food traps | <input type="checkbox"/> Bad breathe |
| <input type="checkbox"/> Broken or missing teeth | <input type="checkbox"/> Cavities |
| <input type="checkbox"/> Cold sores | <input type="checkbox"/> Difficulty opening wide |
| <input type="checkbox"/> Aesthetic concerns | <input type="checkbox"/> Facial surgery |
| <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Gum infection |
| <input type="checkbox"/> Jaw clenching | <input type="checkbox"/> Loose teeth |
| <input type="checkbox"/> Sensitive or bleeding gums | <input type="checkbox"/> Broken filling |
| <input type="checkbox"/> Teeth grinding or clenching | <input type="checkbox"/> Clicking or popping jaw |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Gags easily |
| <input type="checkbox"/> Gum treatments | <input type="checkbox"/> Orthodontic treatment |
| <input type="checkbox"/> Swelling or lumps | <input type="checkbox"/> Growth or lesions |
| <input type="checkbox"/> Unfavorable dental experience | |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in status.

Signature * _____