Patient Information

Patient Name: ____ Date: ____________
Last, First MI (Preferred Name)

Address: ____
Street Apartment #

____
City State Zip Code

Home Phone: ______________ (Work): ______________ Ext: ________

Cell Phone: I consent to the dental practice using my cell phone number to call and/or text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

My cell phone number is ________________________________ __________ (initial)

Email: ________________________________ I agree to information by email: ______________
Initial

Social Security #: ______________ Drivers License #: ______________ Birth Date: __________ Gender: ____

Whom may we thank for referring you to our practice?

Responsible Party if Different from Patient Information

Name: ____ Relationship to patient: ____________
Last, First MI (Preferred Name)

Address: ____
Street Apartment #

____
City State Zip Code

Home Phone: ______________ (Work): ______________ Ext: ________ Cellular Phone: ______________

Email: ________________________________ I agree to information by email: ______________
Initial

Social Security #: ______________ Drivers License #: ______________ Birth Date: __________ Gender: ____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ________________________________ Occupation: ______________________

Address: ____
Street City, State Zip Code Phone

Insurance Information

Primary Insurance Company: ________________________ Group Plan Name: ____________

Name of Insured: ____
Last First MI

Insured's Birth Date: __________ Social Security # ______________ ID # or Group #: ______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Secondary Insurance Company: ________________________ Group Plan Name: ____________

Name of Insured: ____
Last First MI

Insured's Birth Date: __________ Social Security # ______________ ID # or Group #: ______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Health Information

Date of Last Dental Visit: ______________________ Reason for this visit: ____

Have you ever had any of the following? Please check yes or no:

Y	N	Condition	Y	N	Condition	Y	N	Condition	Y	N	Condition
☐	☐	AIDS/HIV	☐	☐	Excessive Bleeding	☐	☐	Liver Disease	☐	☐	Tremors
☐	☐	Anemia	☐	☐	Fainting	☐	☐	Mental Disorders	☐	☐	Tuberculosis
☐	☐	Angina Pectoris	☐	☐	Glaucoma	☐	☐	Migraines	☐	☐	Tumors
☐	☐	Arthritis	☐	☐	Growths	☐	☐	Mitral Valve Prolapse	☐	☐	Ulcers
☐	☐	Artificial Joint	☐	☐	Hay Fever	☐	☐	Nervous Disorders			
☐	☐	Asthma	☐	☐	Head Injuries	☐	☐	Psychiatric Care			
☐	☐	Blood Disease	☐	☐	Heart Attack	☐	☐	Respiratory Problems			
☐	☐	Cancer	☐	☐	Heart Disease	☐	☐	Rheumatic Fever			
☐	☐	Cerebral Palsy	☐	☐	Heart Murmur	☐	☐	Rheumatism			
☐	☐	Chemotherapy/ Radiation therapy	☐	☐	Herpes	☐	☐	Scarlet Fever			
☐	☐	Cold Sores	☐	☐	Hepatitis	☐	☐	Seizures			
☐	☐	Diabetes	☐	☐	High Blood Pressure	☐	☐	Sinus Problems			
☐	☐	Dizziness	☐	☐	High Cholesterol	☐	☐	Stomach Problems			
☐	☐	Drug Alcohol Problem	☐	☐	Jaundice	☐	☐	Stroke			
☐	☐	Epilepsy	☐	☐	Kidney Disease	☐	☐	Thyroid Disease			
						☐	☐	TMJ			

Please list all current medications:
____
____
____
____
____
______

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  - If yes, please explain: ____________________________________
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
- If yes, please explain: ____________________________________
- Are you now under the care of a physician? ☐ Yes ☐ No
  - If yes, please explain: ____________________________________
- Name of Physician: ______________________ Phone: ____________
- Date of last physical: ______________________
- Have you ever taken Fosamax? ☐ Yes ☐ No
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____________________________________
- Have you ever had any reaction or allergy to any of the following? Please check any that apply:

☐ Amoxicillin	☐ Latex	☐ Sulfa	☐ Other
☐ Clindamycin	☐ Motrin	☐ Tetracycline	☐ None
☐ Codeine	☐ Penicillin	☐ Tylenol	
☐ Erythromycin	☐ Pollen	☐ Vicodin	

- **Women only:**
  - Are you pregnant or trying to conceive? ☐ Yes ☐ No
  - Are you nursing? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment, without fail.

Signature of patient, parent or guardian: ______________________________ **Date:** ________________

I have received a copy of the Dental Board of California's Dental Materials Fact Sheet:

____ **Date:** ________________
Signature of patient, parent or guardian

I have received a copy of the HIPAA notice of Privacy Practices:

____ **Date:** ________________
Signature of patient, parent or guardian

Agreement for Payment/Assignment and Release for Insurance

I hereby certify that the above personal and insurance information is correct. I understand that I am financially responsible for all charges incurred by me or my dependents and agree to pay for all charges not covered by my insurance company. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
I hereby assign my insurance benefits directly to Dr. Yoon and authorize the release of information necessary to secure the payment of benefits and authorize the use of my signature on all insurance submissions.
I understand I will be charged for any appointments missed or cancelled without a 48 hour notification.
Patient Payments are collected on the day services are rendered. As a condition of your treatment by this office, financial arrangements must be made in advance. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.
I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form or my dental treatment.

I have read the above conditions of treatment and payment and agree to their content.

______________________________________ Date: __________ Relationship to Patient: ________________
Signature of patient, parent or guardian