Dental History

Reason for today's visit? _____ Date of last dental care: _____

Former Dentist: _____ Date of last dental x-ray: _____

Address: _____City: _____State: _____Zip: _____

Check (☑) if you have had problems with any of the following:

___ Bad Breath ___Grinding teeth ___ Sensitivity to hot
___ bleeding gums ___ Loose teeth or broken fillings ___ Sensitivity to sweets
___ Clicking or popping jaw ___ Peridontial treatment ___ Sensitivity when biting
___ Food collection between the teeth ___ Sensitivity to cold ___ Sores or growth in your mouth

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name: _____ Date of last visit: _____

1. Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionmin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No
2. Have you had any serious illnesses or operations? Yes No If yes, describe: _____
3. Have you ever had a blood transfusion? Yes No If yes, give approximate dates: _____
4. (Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (☑) If you have or have had any of the following:

___Anemia ___ Congenital Heart Lesions ___ Hepatitis ___ Scarlet Fever
___ Arthritis, Rheumatism ___ Cortisone Treatments ___Hernia Repair ___ Shortness of Breath
___ Artificial Heart Valves ___ Cough, Persistent ___ High Blood Pressure ___ Skin Rash
___ Artificial Joints, Pins etc ___ Cough up Blood ___ HIV/AIDS ___ Stroke
___ Asthma ___ Diabetes ___ Jaw Pain ___ Swelling of Feet or Ankles
___ Back Problems ___ Epilepsy ___ Kidney Disease ___ Thyroid Problems
___ Bleeding Abnormally ___ Fainting ___ Liver disease ___ Tobacco Habit
___ Blood Disease ___ Glaucoma ___ Mitral Valve Prolapse ___ Tonsillitis
___ Cancer ___ Headaches ___ Pacemaker ___ Tuberculosis
___ Chemical Dependency ___ Heart Murmur ___ Radiation Treatment ___ Ulcer
___ Chemotherapy ___ Heart Problems ___ Respiratory Disease ___ Venereal disease
___ Circulatory Problems ___ Hemophilia ___ Rheumatic Fever

List Medications you are currently taking and the correlating diagnosis: _____

_____

Allergies: _____

Authorization and Release

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to **Dr. Young Kim** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that the above named dentist may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. In the event that payments are not received as agreed upon, I understand that a 1-1/2% late charge (18% APR) will be added to my account. Lastly, I agree to pay reasonable attorney's fees, court costs and collection costs incurred by this office in collection and enforcement of the debt. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.