



PHILIPPI AND KWON FAMILY DENTISTRY

Welcome to our office! In order to provide you with the best possible service, please fill out this form as completely as possible with black or blue ink. Please let us know if you have any questions or concerns. Thank you!

1 ABOUT YOU

Date: _____

Patient's name: _____
FIRST MI LAST

Preferred name: _____ Gender: MALE FEMALE

Birthdate: _____ Age: _____ SSN: _____

Status: SINGLE MARRIED SEPARATED / DIVORCED WIDOWED

Spouse's name: _____ Number of children: _____
(IF APPLICABLE)

How did you hear about us? _____

Employer: _____ Occupation: _____

Employer's address: _____

2 CONTACT INFO

Mailing address: _____

Home phone: (_____) _____ - _____

Mobile phone: (_____) _____ - _____

Work phone: (_____) _____ - _____ Ext: _____

Email address: _____

3 EMERGENCY CONTACT INFO

Name: _____ Relation: _____

Home phone: (_____) _____ - _____

Mobile phone: (_____) _____ - _____

Work phone: (_____) _____ - _____ Ext: _____

Medical doctor: _____

Medical doctor's phone: (_____) _____ - _____

4 INSURANCE

PRIMARY DENTAL	SECONDARY DENTAL (IF APPLICABLE)
Company name: _____	Company name: _____
Address: _____ _____	Address: _____ _____
Phone: (_____) _____ - _____	Phone: (_____) _____ - _____
Subscriber's name: _____	Subscriber's name: _____
Subscriber's ID: _____ Group number: _____ <small>PLAN, LOCAL, OR POLICY NUMBER</small>	Subscriber's ID: _____ Group number: _____ <small>PLAN, LOCAL, OR POLICY NUMBER</small>
Birthdate: _____ Relation: _____ <small>(IF APPLICABLE)</small>	Birthdate: _____ Relation: _____ <small>(IF APPLICABLE)</small>
Subscriber's employer: _____	Subscriber's employer: _____

5 ACCOUNT INFO

PRIMARY ADULT RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____
(IF APPLICABLE)

SSN: _____ Driver's license number: _____

Billing address: _____

I hereby authorize the assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

INITIALS

5 DENTAL HISTORY

Reason for your visit: EXAM EMERGENCY CONSULTATION

Are you in pain? YES NO If so, please describe. _____

Do you have any of the following problems? Select all that apply.

- CHIPPED TOOTH LOST/DAMAGED FILLING IRRITATED/SWOLLEN GUMS
 LOCKING JAW STAINED TEETH SENSITIVITY IN TEETH/GUMS
 JAW DISCOMFORT TEETH GRINDING SORES IN OR AROUND MOUTH
 BAD BREATH OTHER: _____

Do you require pre-medication? YES NO NOT SURE

Previous dentist: _____ Phone: () _____ - _____

Last dental exam: _____ Last dental X-rays: _____

Times a day you brush? _____ Times a week you floss? _____

What type of tooth brush bristles do you use? SOFT MEDIUM HARD

6 MEDICAL HISTORY

Are you allergic to any of the following: ASPIRIN DENTAL ANESTHETICS LATEX PENICILLIN/AMOXICILLIN TETRACYCLINE FOODS: _____ OTHER: _____

Are you taking any of the following medications: BLOOD THINNERS INSULIN MEDICATION FOR OSTEOPOROSIS MUSCLE RELAXERS NERVE PILLS PAIN KILLERS (including aspirin)

STIMULANTS OTHER: _____

Have you ever taken bisphosphonates (ex. Aredia/Fosamax)? YES NO

Do you have or have you had any of the following diseases, medical conditions, or procedures? Select all that apply, or select no .

- | | | | |
|--------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> ALCOHOL/DRUG ABUSE | <input type="checkbox"/> CONGENITAL HEART DEFECT | <input type="checkbox"/> HEART SURGERY/PACEMAKER | <input type="checkbox"/> RESPIRATORY PROBLEMS |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> COSMETIC SURGERY | <input type="checkbox"/> HEPATITIS A/B/C | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> ARTHRITIS/RHEUMATISM | <input type="checkbox"/> DIABETES/HYPOGLYCEMIA | <input type="checkbox"/> HIGH / <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> SCARLET FEVER |
| <input type="checkbox"/> ARTIFICIAL BONES/JOINTS | <input type="checkbox"/> DIFFICULTY BREATHING | <input type="checkbox"/> HIV+/AIDS/ARC | <input type="checkbox"/> SEVERE/FREQUENT HEADACHES |
| <input type="checkbox"/> ARTIFICIAL VALVES | <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> JAW PROBLEMS (TMJ/TMD) | <input type="checkbox"/> SHINGLES |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> FAINTING/SEIZURES/EPILEPSY | <input type="checkbox"/> KIDNEY PROBLEMS | <input type="checkbox"/> SINUS PROBLEMS |
| <input type="checkbox"/> BACK PROBLEMS | <input type="checkbox"/> FREQUENT NECK PAIN | <input type="checkbox"/> LEUKEMIA | <input type="checkbox"/> STOMACH PROBLEMS/ULCERS |
| <input type="checkbox"/> BLEEDING PROBLEMS | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> LIVER PROBLEMS | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> CANCER/TUMORS | <input type="checkbox"/> HEART ATTACK/STROKE | <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> TUBERCULOSIS (TB) |
| <input type="checkbox"/> CHEST PAINS | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> NERVOUSNESS | <input type="checkbox"/> VENEREAL DISEASE |
| <input type="checkbox"/> CHEMOTHERAPY | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> PSYCHIATRIC PROBLEMS | <input type="checkbox"/> XRAY OR COBALT TREATMENT |

Please list any other surgeries or medical conditions you have or have ever had: _____

Do you use tobacco? YES NO How long? _____ Please rate your general health from 1 to 10: _____ Do you wear contact lenses? YES NO
WHERE 10 IS EXCELLENT

For women: Are you taking birth control? YES NO Are you pregnant? NO YES How long? _____ Are you nursing? YES NO

I understand that full payment is required for all services rendered at the time of my visit, unless other arrangements have been made.

I understand that if my balance is not paid within 90 days from the date of service and no other arrangements have been made, I will be charged a statement fee of 1% of my unpaid balance per month and any other expenses necessary to collect the money I owe.

I authorize the staff of Phillippi and Kwon Family Dentistry to perform any necessary services needed during my diagnosis and treatment.

I authorize the staff of Phillippi and Kwon Family Dentistry to release any information required to process insurance claims.

I certify that I have completed this form to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____

Date: _____

ADULT PARENT/GUARDIAN SPOUSE

Please let us know if you have any questions or concerns. Thank you!