



PHILLIPPI AND KWON FAMILY DENTISTRY

Please fill out this form in its entirety. We need a complete update on your information, including medical history and any insurance you may have. 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

Patient's name: _____
FIRST MI LAST

Status: SINGLE MARRIED SEPARATED / DIVORCED WIDOWED

Birthdate: _____ Age: _____ SSN: _____

Employer: _____ Occupation: _____

Employer's address: _____

2 CONTACT INFO

Mailing address: _____

Home phone: (_____) _____ - _____

Mobile phone: (_____) _____ - _____

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

Email address: _____

3 DENTAL INSURANCE

If you currently have insurance (primary/secondary), please provide us with this information, so that we may file it as a service to you.

If this information is not provided to us, you will be held responsible for **ALL** charges.

INITIALS

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

4 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: _____

Do you require pre-medication? YES NO NOT SURE 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? _____ Do you wear contact lenses? YES NO

Please rate your general health from 1 to 10: _____ (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