PHILLIPPI 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

Company name: _____

Address: _____

_____

Phone: (_____) _____ - _____

Subscriber's name: _____

Subscriber's ID: _____ Group number: _____
PLAN, LOCAL, OR POLICY NUMBER

Birthdate: _____ Relation: _____
(IF APPLICABLE)

Subscriber's employer: _____

SECONDARY DENTAL (IF APPLICABLE)

Company name: _____

Address: _____

_____

Phone: (_____) _____ - _____

Subscriber's name: _____

Subscriber's ID: _____ Group number: _____
PLAN, LOCAL, OR POLICY NUMBER

Birthdate: _____ Relation: _____
(IF APPLICABLE)

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 ❑ CONSULATION

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

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

_____

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 even 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 .

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