

1 PATIENT INFORMATION

Date Today _____ *

Social Security # _____ or ID _____

Patient Name _____
First Name Middle Initial Last Name

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex M F Preferred pronoun _____ Age _____

Birth Date _____ * Marital Status _____

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Spouse's Birth Date _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 DENTAL INSURANCE

Whom is responsible for your office Co Pay? _____ *

Relationship to Patient _____

Insurance Co. _____

Group # _____

Does the patient have 2 dental insurance plans? Yes No

Subscriber's Name _____

Birth Date _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

Sy Kim, DDS, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by Insurance. I authorize the use of my signature on all insurance submissions.

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. This consent will end when my current treatment plan is completed or one year from the date signed below.

 Signature of Patient, Parent, Guardian or Personal Representative

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

 Date

 Relationship to Patient

3 PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (213)842-1284 _____

Spouse's Work (_____) _____ Best time and place to reach you _____

* **IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 DENTAL HISTORY

* Reason for today's visit _____	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____ *	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____ *	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____ *
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____ *
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No	

FIRST NAME: _____ LAST NAME: _____ BIRTHDAY: _____

5 HEALTH HISTORY * Frequently missed questions

Medical Doctor * _____ Date of last visit _____

Have you ever taken oral/IV Bisphosphonate for Osteoporosis or cancer treatment? These include Fosamax, Actonel, Prolia, Denosumab, Avastic, or Sutene. Yes No *

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves <input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Other: _____	Heart Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer (Type _____) <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain <input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck <input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions <input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer <input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody <input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	Other unlisted Disability <input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	Please explain: _____
	High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No	

Patient's Signature Date Doctor's Signature

Women: Are you pregnant? Yes No Due Date _____ Are you nursing? Yes ? No
Taking birth control pills? Yes No
(In case we need to prescribe you antibiotics)

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

* _____

Pharmacy Name _____
Phone (_____) _____

ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (Sleeping pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex	_____

6 PRIVACY PRACTICES

As of January 1st, 2012 the Dental Board of California now requires that we show our patients a copy of the Dental Materials Fact Sheet. In addition, the Health Insurance Portability and Accountability Act (HIPAA) requires as of 2003, that patients also be shown a copy of our Notice of Privacy Practice. We would be glad to make you a copy upon request or e-mail it to you. Please sign your name below verifying that you have seen these documents. I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

I, _____, acknowledge I have seen the Notice of Privacy Practices and the Dental Materials Fact Sheet.

Signature of Patient/Parent/Guardian/Personal Representative

* _____
PRINTED NAME of Patient/Parent/ Guardian/Person Representative Date Relationship to Patient

* Frequently missed questions

DR.SY KIM DDS

(916) 487-5032

OFFICE POLICY

TODAY'S DATE:

FIRST NAME: Me

LAST NAME: Test

BIRTHDAY: 03/12/1880

Welcome to Sy Kim, DDS, Inc.,

Please read the below explanation of our policies regarding treatments and financial matters.

We believe that service to our patients is at its best when there is complete understanding and mutual cooperation.

1. Payments. The payment is required at the time of dental service.

2. Insurance. I, Me Test the undersigned, have dental insurance coverage with Delta Dental of California and assign directly to Sy Kim, DDS, Inc. all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

Your insurance is a contract between you, your employer and the insurance company.

Our office is not a party to that contract. Not all services are a covered benefit in all contracts.

Some insurance companies arbitrarily select certain services they will not cover.

I hereby authorize the office to release all information necessary to secure the payment of benefits.

I authorize the use of this signature on all my insurance submissions.

3. Late Charges. If payment are extended 30 days from the date of treatment completion. I agree to pay 1.5% interest per month on the unpaid balance (annual percentage rate 18%).

4. Overdue Account. If an account is past due, we cannot provide any active treatment until the account is brought up to date.

5. Returned Checks. Checks returned for insufficient funds will be subject to a \$25 service charge.

6. Credit. In case of overpayment, you will be reimbursed at the end of treatment.

7. Broken Appointments. We realize that once in a while you may have to reschedule the appointment.

We appreciate receiving a 48 hour notice. And it does not include weekends or holidays. We

have reserved the appointment time for you and

a missed appointment means that our time could have been spent with another patient.

We will charge you \$75 for hygienist appointment and \$200 for doctor's appointment

for every broken appointment without 48 hour notice prior to your scheduled appointment.

8. Duplication. You are entitled to have duplications of any documents from your own chart. Some duplication may require fees and this process may take up to 10 business days.

9. In the event of a suit or referral to collect, I agree to pay, in addition to the unpaid balance, all attorneys' fees and filing fees of \$25, court costs and additional collection fee of \$295.00.

Signature of Patient/Guardian: _____