Date:____________________

Welcome

Thank you for selecting our dental healthcare team. Dr. Jong and Dr. Choi will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us, we will be happy to help you.

Please print:

Patient Information (CONFIDENTIAL)

Name____Home Phone________________

Address____________________________City______________State________Zip Code________

Date of Birth______________________________ Sex: ❑M ❑F Soc. Sec. No______________

Check appropriate box: ❑Minor ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Patient's Employer/School________________________________Work Phone______________

Email Address______________________ Emergency Contact (   )   -

Whom may we thank for referring you?____

Responsible Party (Ex: Parents, Spouse, Caregiver, Nursing home, P.O.A, etc.)

Name of person responsible for this account______________________________________

Relationship to Patient ______________________________Home Phone________________

Address____

Soc. Sec. No.____Birthdate______________

Employer____Work phone_______________

Is this person currently a patient in our office? ❑Yes ❑No

Dental Insurance Information:

Name of Insured ______________________________ Relationship to Patient__________

Subscriber's Birthdate______________________Soc. Sec. No.________________________

Name of Employer _______________________________Work Phone____________________

Name of Dental Insurance Co. ______________________________Group No.___________

Ins. Co. Address______________________City_____________State_______Zip code_______

Do you have additional dental insurance? ❑Yes ❑No If yes complete the following:

Name of Insured ______________________________ Relationship to Patient__________

Subscriber's Birthdate______________________Soc. Sec. No.________________________

Name of Employer _______________________________Work Phone____________________

Name of Dental Insurance Co. ______________________________Group No.___________

Ins. Co. Address______________________City_____________State_______Zip code_______

Other side

Medical History:

	Yes	No
1) Are you under medical treatment now?	☐	☐
2) Have you ever been hospitalized for any surgical operations or serious illness?	☐	☐
3) Are you taking any medication(s) **including non-prescription** medications?	☐	☐

If yes, please list **all** medications you are currently taking:

____

____

____

	Yes	No
4) Do you use tobacco?	☐	☐
5) Do you use alcohol, cocaine or other drugs?	☐	☐
6) Do you take an **aspirin daily**? ____mg	☐	☐
7) Are you allergic to any of the following:		
Local anesthetics (ex. Novocain)	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

____

8) Women only	Yes	No
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control?	☐	☐

Do you suffer from any of the following?

	Yes	No
High Blood Pressure	☐	☐
Heart attack	☐	☐
Low blood pressure	☐	☐
Heart disease	☐	☐
Cardiac pacemaker	☐	☐
Heart Murmur	☐	☐
Rheumatic Fever	☐	☐
Fainting	☐	☐
Asthma	☐	☐
Epilepsy/Convulsions	☐	☐
Leukemia	☐	☐
Diabetes	☐	☐
Kidney Diseases	☐	☐
HIV/AIDS	☐	☐
Radiation Therapy	☐	☐
Anemia	☐	☐
Emphysema	☐	☐
Cancer	☐	☐
Hepatitis	☐	☐
Liver Disease	☐	☐
Joint Replacement	☐	☐
Stroke	☐	☐
Tuberculosis	☐	☐

Please list any others:

____

____

Dental History:

1) Are your teeth sensitive to hot, cold, sweet or sour liquid/food?
2) Do you feel pain in any of your teeth?
3) Have you ever had difficult extractions in the past?
4) Have you ever had prolonged bleeding following and extraction?
5) Date of last x-ray series is ____________________
6) Are you interested in teeth whitening?________Invisalign?_________

Authorization and Release

I confirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my medical status. I authorize the dental staff to perform the necessary dental service I may need. My method of payment will be ________________. I certify that I am covered by ____________________________ Insurance Company and I assign directly to this dental office all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of service rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electric. By signing my signature, I have read and understand all of the above.

Signature:____Date:__________________________