Jangsook Kim DDS

PATIENT REGISTRATION

PATIENT INFORMATION

Date: _________

Name ______________________ Date of birth ____________ Age ________

SSN # ______________________ ❑ Male ❑Female Marital Status ❑Single ❑Married

Address ______________________ City ____________ State ________ Zip ________

Phone # ____________ Cell phone ____________ E-mail ____________

GETTING TO KNOW YOU

` Employed by _______________________ Occupation _______________________

` Are any of your family members or relatives patients in our office? ❑Yes ❑No

Please, list them: ____

`In case of an emergency, who should we contact?

Name _______________________________ Relationship _______________ Phone # ____________________

`How do you prefer to be contacted? ❑Phone call ❑text message ❑e-mail ❑ all of them

`How did you hear about us?

❑ Insurance ❑ Internet ❑ Church ❑ Walk in/ Drive by ❑ Korean Life ❑Santa Clarita Magazine

❑ Patient _______________❑ Doctor ________________❑ Other ______________❑ Valley Magazine

DENTAL COVERAGE

` Primary Carrier

Insurance Company ____________________ Employer Name ____________

Insured's Name ____________________ Relationship to patient ____________

Insured's ID or SSN # ____________________ Date of birth ____________

` Secondary Carrier

Insurance Company ____________________ Employer Name ____________

Insured's Name ____________________ Relationship to patient ____________

Insured's ID or SSN # ____________________ Date of birth ____________

I understand that all services are due and payable at the time of services are rendered unless other financial arrangements have been previously approved. Should my account exceed sixty days, 1.5% interest per month will be charged. There are no guarantees of insurance benefits. In the event of default of payment, I agree to be responsible for all attorney fees and other court costs.

The above information is accurate and completed the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staffs responsible for any errors or omissions that I may have made in the completion of this form.

Patient Name ______________________ Signature ______________________ Date __________

MEDICAL HISTORY

1. Have you been under care of a medical doctor during the past two years? Yes No
   If yes, for what? ______________________ Physician's Name ______________________
2. Are you taking any medication, drugs or pills, including regular dosages of aspirin? If yes, please list all within the last 2 years, name and dosage ______________________ Yes No
   ____
3. Are you aware of having an allergic reaction to any medication or substance? If yes, please list ______________________ Yes No
4. Have you been a patient in the hospital during the past five years? If yes, please describe ______________________ Yes No
5. Are you pregnant? Yes No Months? ____ Are you breastfeeding? Yes No Taking birth control pills? Yes No
6. Have you ever had any unfavorable reaction to a dental treatment? Yes No
   If yes, please explain ______________________

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item

Condition			Condition		
AIDS / HIV	Yes	No	Neurological disorders	Yes	No
Alcoholism	Yes	No	Osteoporosis	Yes	No
Allergies or hives	Yes	No	Pacemaker	Yes	No
Anemia	Yes	No	Penicillin allergies	Yes	No
Arthritis, rheumatism	Yes	No	Phen-fen use	Yes	No
Artificial joints	Yes	No	Psychiatric care	Yes	No
Asthma	Yes	No	Psychological care	Yes	No
Bleeding problems	Yes	No	Radiation therapy	Yes	No
Blood disease	Yes	No	Rheumatic fever	Yes	No
Bruise easily	Yes	No	Sickle cell disease	Yes	No
Cancer	Yes	No	Sinus trouble	Yes	No
Chemotherapy	Yes	No	Smoking	Yes	No
Chest pain	Yes	No	Stomach ulcer	Yes	No
Chronic cough	Yes	No	Stroke	Yes	No
Cold sores, fever blisters	Yes	No	Swollen ankles	Yes	No
Congenital heart disease	Yes	No	Thyroid problems	Yes	No
Contact lenses	Yes	No	TMJ problems	Yes	No
Cortisone Medicine	Yes	No	Tuberculosis	Yes	No
Diabetes	Yes	No	Tumors	Yes	No
Emphysema	Yes	No	Ulcers	Yes	No
Epilepsy or seizures	Yes	No	Venereal Disease	Yes	No
Fainting or dizzy spells	Yes	No	Yellow Jaundice	Yes	No
Glaucoma	Yes	No			
Hay fever	Yes	No			
Headache	Yes	No			
Heart attack, surgery	Yes	No			
Heart murmur	Yes	No			
Hemophilia	Yes	No			
Hepatitis A or B	Yes	No			
High blood pressure	Yes	No			
Kidney disease	Yes	No			
Latex allergies	Yes	No			
Liver Disease	Yes	No			
Low blood pressure	Yes	No			
Nervous disorders	Yes	No			

Do you have or have you had any disease, condition or problem not listed? If yes, please list Yes No

____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient Name	Signature	Last updated	Dentist Signature

2ND YEAR MEDICAL HISTORY UPDATE Has there been any change in your health since your last dental appointment? Yes No
If yes, please explain………

Patient Name	Signature	Last updated	Dentist Signature

3RD YEAR MEDICAL HISTORY UPDATE Has there been any change in your health since your last dental appointment? Yes No
If yes, please explain ………

Patient Name	Signature	Last updated	Dentist Signature