Rainier Ave. Dental

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Dr. Jiyon Kim and Dr. Sang C. Kim

Patient Registration

Name_____ Address_____

City_____ Zip_____ Home# _____Cell# _____Work# _____

Sex ___**F** ___**M** Marital Status **S M D** Birth date _____ **SS#**_____-_____-_____
(Circle one) **(Only needed if used as insurance ID#)**

Email address _____

Patient Employed by_____ Business Address_____

In case of emergency notify, _____ Phone_____
(Name and relationship)

Whom may we thank for referring you? _____

Dental Insurance

Primary	Secondary
SUBSCRIBERS'S NAME	SUBSCRIBERS'S NAME
DATE OF BIRTH	DATE OF BIRTH
INSURANCE COMPANY	INSURANCE COMPANY
SUBSCRIBER #	SUBSCRIBER #
GROUP #	GROUP #
EMPLOYER	EMPLOYER
OCCUPATION	OCCUPATION

Dental History

Previous Dentist _____

Address _____(_____) _____
Number Street City State Zip Telephone

Date of last dental visit_____ Date of last dental x-rays _____ Reason for leaving _____

Are your teeth affecting your general health?	YES NO	Have you experienced prolonged bleeding or slow			
Are you satisfied with your teeth and gums?	YES NO	healing after a tooth extraction?	YES NO		
Do you have sore or sensitive teeth?	YES NO	Have you had orthodontic treatment (braces)?	YES NO		
Have you ever been treated for periodontal disease?	YES NO	Are you aware of grinding or clenching your teeth day or night?	YES NO		
Have you ever had serious complications with dental treatment?	YES NO	Have you neglected regular dental visits in the past?	YES NO		
Do you want your teeth to be whiter?	YES NO	Are you dissatisfied with the appearance of your teeth?	YES NO		

How often do you brush? _____How often do you floss? _____ **Tell us about your dental health**: _____

_____

Medical History

Physician Name: _____ Phone: _____ Date of last health care exam: ____/____/____

What was the exam for? _____ Have you been hospitalized in the last 5 years? (Please circle) **NO YES**

If yes, reason: _____

Medications:

Are you taking blood thinners such as aspirin or coumadin? _____

Are you currently taking any medications, prescription or over the counter drugs? (Please circle) **NO YES** If yes, please list: _____

_____

Are you required to Pre-medicate before dental treatment? (Circle) **NO YES** if yes, reason _____

Are you a smoker? (Circle) **NO YES** If so, how much per day and for how long? _____

Are you taking or have you ever taken fosomax or any biophosphonate related drugs? (Circle) **NO YES**

Please check any of the following which you have now or have had in the past. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked questions concerning your response.

__HIV infection/AIDS
__ HIV positive/AIDS
__Anemia
__Blood Transfusion
__Headaches
__Artificial joints
__Asthma
__Back problems
__Blood Disease
__Cancer
__Chemical Dependency
__Chemotherapy
__Circulatory Problems
__Cough, Persistent
__ Cosmetic Surgery
__ Fainting
__ Artificial heart valves
__Glaucoma
__Radiation Therapy
__Heart Attack
__Heart Murmur
__Heart Problems
Describe: _____
__Hemophilia
__Diabetes
__High/low Blood Pressure
__Liver Disease (Jaundice)
__ Emphysema
__ Heart Pacemaker
__ Bruise Easily
__Psychiatric Care
__Sickle Cell Disease
__Respiratory Disease
__Rheumatic/Scarlet Fever
__ Shingles
__Shortness of Breath
__Swelling, feet/ankle
__Hepatitis (type) _____
__Tobacco Habit
__ Fever Blisters/Cold Sores
__ Seizures
__ Arthritis/Rheumatism
__Venereal Disease
__ Anxiety Disorder
__ Lupus
__Epilepsy
__Mitral Valve Prolapse
__Kidney Disease
__ Stomach Ulcers
__Thyroid Problem
__Tuberculosis

Is there anything else you would like us to be aware of? _____

Are you being treated for any illness now? (Circle) **NO YES** if yes, please explain: _____

_____

Please list any allergies you have: _____

Women: Are you pregnant? **NO YES**
If no, are you planning a pregnancy in the near future? **NO YES**
Are you nursing? **NO YES**
Are you taking birth control pills? **NO YES** if yes, please list: _____

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 information to you. I will notify the dentist of any changes in my health or medications.

Patient's Signature: _____ **Date**: _____/_____/_____

Financial Policy Agreement
Optional Payment Terms:

1. **2 Payment Option**: We offer a two-payment option for Crown, Bridge, and Denture treatment. We ask that you pay one-half of your co-payment at the first appointment and the balance due at the second appointment.
2. **Discount Plans:** Patients on the AmeriPlan or Carington dental plans will not receive any additional discounts.
3. **Care Credit**: We offer our patients, upon approval, a financing program with no down payment, several different payment options which are customized to your individual needs and no prepayment penalty. Please ask for an application.

Payments are due at the time services are rendered.

To maintain the practice operations and to prevent potential misunderstandings, we ask patients to accept and adhere to financial arrangements regarding their dental treatment. We accept cash, checks, ATM cards, and all major credit cards.

Acknowledgment Receipt of Notice of Privacy Practices

I, _____, have received a copy of the 4th & Morris Dentistry Privacy Practice,
(Print Name)
Financial Policy and I authorize the assignment and release form.

_____ _____
Patient's Signature *Date*

_____ _____
If patient is a minor: Parent/Guardian's Signature *Date*