

## Patient Information

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name \_\_\_\_\_  
First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_

E-mail \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Sex ☐ M ☐ F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for \_\_\_\_\_ years

Patient Employer/School \_\_\_\_\_

Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## Dental Insurance

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ 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)

Dr. Joung Eun Song, D.D.S. 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 \_\_\_\_\_

## Phone Numbers

Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

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 (\_\_\_\_) \_\_\_\_\_

## Dental History

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

## Dental Registration and History



## Health History

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ 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 |
| Asthma                                              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, with<br>extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer                                              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy                                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis                       | <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 | Tumor or growth on head<br>or neck | <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 | Ulcer                              | <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 | Venereal Disease                   | <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 | Weight Loss, unexplained           | <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 |                                    |                                                          |

Do you wear contact lenses? ☐ Yes ☐ No

### Women:

Are you pregnant? ☐ Yes ☐ No

Due date \_\_\_\_\_

Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No



## Medications

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

\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_



## Allergies

☐ Aspirin

☐ Local Anesthetic

☐ Barbiturates (Sleeping pills)

☐ Penicillin

☐ Codeine

☐ Sulfa

☐ Iodine

☐ Other \_\_\_\_\_

☐ Latex



## Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_