PATIENT INFORMATION

CONFIDENTIAL

PATIENT LAST NAME:

PREFERRED LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ KOREAN ☐ OTHER _____ DATE _____

NAME _____ BIRTHDATE _____ HOME PHONE _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE _____ ZIP _____

E-MAIL _____ CELL PHONE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR
PARENT/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE OR
PARENT/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY _____ STATE _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ FINANCIAL INSTITUTION _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

PATIENT NUMBER#

INSURANCE INFORMATION

NAME OF INSURED _____ _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS# _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS# _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

SIGNATURE

X _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

PATIENT INFORMATION CONTINUED

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT LAST NAME:

PATIENT MEDICAL HISTORY

PHYSICIAN: _____ OFFICE PHONE: _____ DATE OF LAST EXAM: _____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGERY OR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐
IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____		
4. HAVE YOU EVER TAKEN BISPHOSPHONATES?	☐	☐
5. DO YOU USE TOBACCO?	☐	☐
6. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	☐	☐
7. ARE YOU WEARING CONTACT LENSES?	☐	☐

8. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE ROLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	LOCAL ANESTHETICS (E.G. NOVOCAINE)	☐	☐	BARBITURATES	☐	☐	ASPIRIN
☐	☐	PENICILLIN OR OTHER ANTIBIOTICS	☐	☐	SEDATIVES	☐	☐	LATEX
☐	☐	SULFA DRUGS	☐	☐	IODINE	☐	☐	OTHER _____

	YES	NO
9. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARLING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)?	☐	☐
10. WOMEN ONLY:		
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

11. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	HIGH BLOOD PRESSURE	☐	☐	HEART DISEASE	☐	☐	CHEST PAINS
☐	☐	HEART ATTACK	☐	☐	CARDIAC PACEMAKER	☐	☐	EASILY WINDED
☐	☐	RHEUMATIC FEVER	☐	☐	HEART MURMUR	☐	☐	STROKE
☐	☐	SWOLLEN ANKLES	☐	☐	ANGINA	☐	☐	HAY FEVER / ALLERGIES
☐	☐	FAINTING / SEIZURES	☐	☐	FREQUENTLY TIRED	☐	☐	TUBERCULOSIS
☐	☐	ASTHMA	☐	☐	ANEMIA	☐	☐	RADIATION THEREAPY
☐	☐	LOW BLOOD PRESSURE	☐	☐	EMPHYSEMA	☐	☐	GLAUCOMA
☐	☐	EPILEPSY / CONVULSIONS	☐	☐	CANCER	☐	☐	RECENT WEIGHT LOSS
☐	☐	LEUKEMIA	☐	☐	ARTHRITIS	☐	☐	LIVER DISEASE
☐	☐	DIABETES	☐	☐	JOINT REPLACEMENT OR IMPLANT	☐	☐	HEART TROUBLE
☐	☐	KIDNEY DISEASES	☐	☐	HEPATITIS / JAUNDICE	☐	☐	RESPIRATORY PROBLEMS
☐	☐	AIDS OR HIV INFECTION	☐	☐	SEXUALLY TRANSMITTED DISEASE	☐	☐	OTHER _____
☐	☐	THYROID PROBLEM	☐	☐	STOMACH TROUBLES / ULCERS			_____

COMMENTS

_____

_____

_____

_____

_____

SIGNATURE OF DENTIST DATE

PATIENT DENTAL HISTORY

	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	☐	☐
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	☐	☐
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	☐	☐
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
6 HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	☐	☐
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
A) CLICKING?	☐	☐
B) PAIN (JOINT, EAR, SIDE OF FACE)?	☐	☐
C) DIFFICULTY IN OPENING OR CLOSING?	☐	☐
D) DIFFICULTY IN CHEWING?	☐	☐

	YES	NO
8. DO YOU HAVE FREQUENT HEADACHES?	☐	☐
9. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
10. DO YOU BITE YOUR LIPS OR CHEEKCS FREQUENTLY?	☐	☐
11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
12. HAVE YOU HAD ANY ORTHODONTIC WORK?	☐	☐
13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	☐	☐
14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	☐	☐
15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?	☐	☐

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X _____ _____

PATIENT, PARENT OR GUARDIAN DATE

HOW DID YOU FIND OUT ABOUT OUR OFFICE? _____

☐ GOOGLE ☐ YELP ☐ FACEBOOK ☐ FRIEND ☐ DOCTOR

Agreement to Receive Electronic Communication

Patient Name: _____ Date of Birth:_____

(Initial below)

I _____ DO AGREE

I_____ DO NOT AGREE

That the dental practice may communicate with me electronically at the email address and/or mobile phone number listed below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.

My most preferred method of electronic communication:

(Initial below)

____Text Messaging and My Text # :_____

____ Email and My Email address :_____

I would like to receive:

____ Appointment Reminders/Recall Visits

____ Information regarding insurance/billing

____ Requests for Patient Satisfaction online reviews

I can withdraw my consent to electronic communications at anytime by calling:

Yong & Kim Dentistry Tel (714) 535- 0192

101 E. Lincoln Ave # 100 Anaheim, CA 92805

Patient or Guardian Signature: _____

Date:_____

General Dentistry Informed Consent

Patient's Name _____DOB :_____

1. WORK TO BE DONE

I understand that I am having the following work done: [ ] filling [ ] bridges [ ] crowns [ ] extractions [ ] impacted teeth removed [ ] root canals [ ] dentures [ ] exam [x] x-rays [ ] prophy [ ] others (initials _____) (initials _____) (initials _____)

2. DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting and or anaphylactic shock. (initials _____)

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, for example root canal therapy following routine restorative procedures. I give my permission to the dentist to make any / all changes and additions as necessary. (initials _____)

4. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the dentist to have the following teeth removed_____ and any others necessary for reason in paragraph # 3. I understand removing teeth does not always remove all infections if present and it may be necessary to have further treatment by a specialist if complications arise during or after treatment, the cost of which is my responsibility (initials _____)

5. CROWNS, BRIDGES AND VENEERS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge or veneer (including shape, size, fit and color) will be before cementation. It is also my responsibility to return for permanent cementation within 30 days from tooth preparation. Excessive delays may allow for tooth movement. This may cause for remakes due to my delayed permanent cementation

(initials_____) (initials_____) (initials_____) (initials_____)

6. ENDODONTIC TREAMENT (ROOT CANAL)

I realize that there is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the root which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost, despite all efforts to save it. (initials_____) (initials_____)

7. PERIODONTAL LOSS (TISSUE AND BONE)

I understand that I have a serious condition causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and or extractions. I understand that under taking any dental procedures may have a future adverse effect on my periodontal condition. (initials_____) (initials_____)

8. FILLINGS

I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. (initials_____) (initials_____) (initials_____)

9. DENTURES

I understand the wearing of dentures is difficult, sore spots, and altered speech and difficulty in eating are common problems. Immediate denture (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. I understand a remake is required due to my delays of more than 30 days and there will be additional charges.

(initials_____) (initials_____)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which requested and authorized. I understand that each dentist is an individual practitioner and is individually responsible for the dental care given to me. I here by authorize any of the doctors or auxiliaries of Yong & Kim Dentistry to proceed with and perform the dental restorations and treatment as explained to me. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court cost that may be incurred to satisfy this obligation. Should any dispute arise over dental services provided to me, that is whether any dental service is rendered as allegedly unnecessary, unauthorized or was improperly negligently, or incompetently performed, said dispute will be submitted to Peer review by the local Component of the American Dental Association. The decision of Peer review shall be binding on both parties. I have read, understood, and agree to the above. I agree that a photocopy of this authorization shall be as valid and effective as the original forever. I am of legal age and legally competent to make this assignment.

Patient Signature: _____ Date_____

Doctor: _____ Witness:_____

POLICIES AND PROCEDURE CONSENT FORM

_____ HIPAA
☐ *Initial*

I consent to the use and disclosure of my protected health information in order to any treatment, payment activities and healthcare operations by Yong and Kim Dentistry. I have the right to read the Notice of Privacy Practices before deciding to sign this consent. This is notice provides a description of the uses and disclosures taken to my protected health information and other important matters about my protected health information. I also have the right to revoke this consent at any time by giving Yong and Kim Dentistry written notice of revocation submitted to the office manager or treatment provider. Notice: Revocation of this consent will not affect any action taken in reliance on this consent before receiving the revocation and that Yong and Kim Dentistry may decline to give treatment or to continue treatment once this consent is revoked.

_____ DENTAL MATERIALS FACT SHEET
☐ *Initial*

I acknowledge that I have been made aware of the Dental Fact Sheet developed by the Dental Board of California. I understand that his sheet is available to me in an effort to ensure that I am fully informed of a variety of materials available for dental restorations. I understand that I should review this information to make fully informed decisions regarding dental restorative treatment. I also understand that if I have questions or concerns regarding this information that it is my right to have a discussion regarding this aspect of my care with the dentist.

_____ ACKNOWLEDGE UNDERSTANDING /ACCEPTANCE OF FOLLOWING OFFICE POLICIES
☐ *Initial*

1. 24 hours advance Cancellation Policy - Each patient is required to provide advanced notice to allow Yong and Kim Dentistry to arrange the appointments. We do understand that personal emergencies do arise and will always take that into consideration. However, Failure to notify any cancellation of appointments 24 advance will result in a $ 25 fee to patients account. Prior to 24 hours, the patient will be responsible to inform any cancel or reschedule requests by calling or text or leave a message at 714-535-0192. This will allow practice to schedule other patients in wait list or emergency cases.

2. Payment - Copay or payments are due when services are rendered. An estimate of your financial responsibilities shall be provided prior or during your visit.

3. Insurance Claims - We are contracted with most insurance companies and as a courtesy, practice will process insurance claim on patient's behalf, but you are still responsible for the payment of services rendered. Any claim outstanding after 60 days will be billed directly to patient. Any unpaid balance after 60 days will be submitted to collections agency and 3% monthly late fee will be added to the outstanding balances

3. Information updates – Each patient is responsible to update any changes to health, medication, insurance coverage, termination, and /or personal information

Signature (patient or parent/guardian) _____ 

Today's Date _____ 

Yong & Kim Dentistry

Dental Financial Policy - Insurance Patients

The following financial policy applies to all patients who have insurance coverage. Please carefully read and sign this agreement. Let our finance staff know, if you have any questions.

1. We will be happy to bill your insurance company for your care providing you give us all the information we need. Even though you have insurance coverage, please remember that paying for your dental care is you personal responsibility.
2. You will need to pay your portion of the charges as you go. This includes the annual deductible, co-payment and charges your insurance company refuses to pay. Our office policy does not allow us to extend credit.
3. We will need to verify your insurance benefits by contacting the insurance company. We will also have you sign other forms as needed.
   Please note: until we have verified your coverage, you will be responsible for paying for your own care at each visit including the first visit. After we verify your coverage, we will credit the amount you have paid to your portion of the bill.
4. We will bill your insurance company at the time of your dental service. Payment is expected within 60 days. We will automatically transfer and bill you for any payments not received from your insurance company after 60 days. You need to pay us in full at that time. Any amounts you personally owe that are 30 days late will receive a service charge of 3% per month. All legal and collection costs incurred for collection of past due amount will be charged to the guarantor and the patient.
5. Occasionally an insurance company will send a payment to a patient. If this occurs, bring us the check and the attached stub. The information on the stub is very important.
6. Your insurance company may request additional information from you. Please send the information to them right away. They will not pay your claim until they receive the information.
7. If you suspend or terminate your care against the advice of your doctor, all outstanding charges that have not been paid by you or your insurance will become immediately due and payable by you personally before you leave.
8. **APPOINTMENT CANCELLATION POLICY**
   Please note that there will be a $ 25.00 charge for any missed appointment without a 24 hour notice.
9. **MINOR / CHILD CONSENT**
10. I agree that parents/ guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.
11. **ASSIGNTMENT AND RELEASE**
    I,Undersigned, have insurance with _____
    Name of Insurance company(ies)
    And assign directly to Yong & Kim Dentistry all benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize the practice 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 electronic.

By signing below you agree to follow this policy.

_____ _____

Patient / Guardian **Date**

_____

Print Name