PATIENT INFORMATION FORM

Welcome

TO THE OFFICE OF DR. ALEXANDER J. KIM

Patient Name: _____ **Preferred Name**: _____
First Name Middle Initial Last Name Nickname

Home Phone: ( ) _____-_____ **Work Phone:** ( ) _____-_____ **Cell Phone:** ( ) _____-_____

Address: _____ **City/State/Zip:** _____

SS# _____-_____-_____ **DOB:** _____/_____/_____ **Driver's License#:** _____

Gender: ❑Male ❑Female **Family Status:** ❑Single ❑Married ❑Divorced ❑Widowed **Email address:** _____

Employer's Name: _____ **Occupation:** _____

Employer's Address: _____

Spouse's Name: _____ **Occupation:** _____

Spouse's Employer: _____
Name of Company Address of Company Phone Number of Company

Emergency Notification: _____
Name of Relative/Friend Address of Relative/Friend Phone Number of Relative/Friend

Whom may we thank for referring you to our office? ❑Dentist: _____ ❑Friend/Relative: _____

PATIENTS WITH DENTAL INSURANCE FILL OUT INFORMATION *(Please Print)*

PRIMARY Insurance Information

Policyholder: _____ ☐ Self
Ins. Carrier: _____
Ins. Address: _____
Insurance Company Phone # _____
Group/Policy/Plan# _____
Policyholder's Social Security# _____-_____-_____
Policyholder's Date of Birth: _____/_____/_____
Policyholder's Employer: _____
Employer's Address: _____

SECONDARY Insurance Information

Policyholder: _____ ☐ Self
Ins. Carrier: _____
Ins. Address: _____
Insurance Company Phone # _____
Group/Policy/Plan# _____
Policyholder's Social Security# _____-_____-_____
Policyholder's Date of Birth: _____/_____/_____
Policyholder's Employer: _____
Employer's Address: _____

FINANCIAL RESPONSIBILITY and CANCELLATION AGREEMENT

I hereby authorize the release of any information relating to insurance claims to this insurance carrier. I authorize insurance payments directly to Jespersen & Kim D.D.S., Inc. / Jespersen & Jespersen D.D.S., Inc. / AJK Dental I understand that I will be personally responsible for payment of bills if not paid by my insurance carrier. I understand that if my account is over 30 days, my account is subject to late payment charges on the unpaid amount at the rate of 10% per year (or 1.5% per month). I understand that if I have no dental insurance coverage then payment is due at the time treatment is rendered unless other arrangements are made. I understand that my scheduled appointments are reserved and that at least a 48-hour notice be given if any appointments change is absolutely necessary. I understand that I will be charged $75 for missed or cancelled appointment without 48-hour prior notice. Messages left on office voicemail will not be accepted.

Policyholder/Responsible Party Signature: _____Date: _____

PLEASE CONTINUE ON REVERSE SIDE ➔

PATIENT INFORMATION FORM

MEDICAL HISTORY Have you ever had any of the following? *(Please check / circle those that apply)*

- ☐ Alcohol/Chemical Dependency
- ☐ Allergies (Hay Fever)
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints (prosthetic joints)
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Blood Disorder
- ☐ Blood Transfusion Date_____
- ☐ Chest pain or Angina
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy/Fainting Spells
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Gastrointestinal Problems
- ☐ Head / Back / Neck Aches
- ☐ Heart Attack Date_____
- ☐ Heart Murmur / MVP
- ☐ Heart defect from birth
- ☐ Heart Disease
- ☐ Heart Valve Replacement Date ____
- ☐ Hepatitis Type _____
- ☐ High Blood Pressure
- ☐ HIV / AIDS / ARC
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mental Disorder
- ☐ Nervous System Disorder
- ☐ Osteoporosis / Osteopenia
- ☐ Pacemaker Placed: ☐ Before 1980 ☐ After 1980
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke Date_____
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other: _____

☐ Cancer Treatment: Type _____ Date Diagnosed: _____ ☐ Radiation ☐ Chemotherapy _____

☐ **Allergies to:** ☐ Aspirin ☐ Codeine ☐ Penicillin ☐ Sulfa ☐ Novicaine ☐ Latex ☐ Other:_____

_____

Were you ever treated for Osteopenia / Osteoporosis / Pagets Disease with ORAL Bisphosphonates such as Fosamax, Actonel, Boniva,Aredia? ☐ No ☐ Yes (circle medication)

Were you ever treated with INTRAVENOUS Bisphosphonates? ☐ No ☐ Yes (circle medication) Zometa(Zolendronate) / Pamidronate (Aredia) / Ibandronate(Boniva) / _____

Name of Physician: _____ Physician Phone: _____ Date of Last Visit: _____

Are you under the care of a physician? ☐ No ☐ Yes If Yes, please explain: _____

Have you been admitted to a hospital or needed emergency care, or had serious illness in past 5 yrs.? ☐ No ☐ Yes If yes, explain _____

_____

Are you taking any prescription medications? ☐ No ☐ Yes List: _____

_____

Are you taking any non-prescription medications (over the counter)? ☐ No ☐ Yes List: _____

Have you EVER smoked cigarettes / cigars / chew tobacco? ☐ No ☐ Yes ☐ Quit: date:_____Number of Packs per day_____ Number of years: _____

Is there anything of importance in your medical history that has not been asked? If so, explain:

_____

For Women Only: • Is there any chance you are pregnant? ☐ No ☐ Yes If yes, how many months: _____ • Are you breast-feeding? ☐ No ☐ Yes

DENTAL HISTORY *(Please check those that apply)*

Your General Dentist: _____ **General Dentist Phone: (** **)** _____-_____

Reason for seeking dental treatment: _____

Any concerns about appearance or function of teeth? _____

Do you have any problems with the following?

- ☐ Pain in tooth / jaw / face: ☐ Dull Ache ☐ Throbbing ☐ Pressure

If so, Where?_____

When were symptoms first noticed?_____

- ☐ Pain in head or neck If so, Symptoms _____
- ☐ Sensitivity to: ☐ Hot ☐ Cold ☐ Sweets ☐ Biting / Chewing
- ☐ Sores on lips or in mouth
- ☐ Food sticking between teeth
- ☐ Bleeding gums when flossing
- ☐ Bleeding gums when brushing
- ☐ Grinding or clenching your teeth
- ☐ Swelling or pain of gums
- ☐ Loose tooth or teeth
- ☐ Pus around teeth or gum area
- ☐ Bad breath
- ☐ Receding gums

Have you ever had any of the following?

- ☐ Tooth extraction / oral surgery _____
- ☐ Injury to your teeth / jaws
- ☐ Periodontal root planning (deep cleaning) or periodontal surgery
- ☐ Removable dentures ☐ Upper ☐ Lower ☐ Partial denture ☐ Complete denture
- ☐ Loose denture or partial denture
- ☐ Bridges
- ☐ Implants
- ☐ Cosmetic dental treatment
- ☐ Orthodontic treatment
- ☐ Unusual reaction to dental treatment - Explain:

AUTHORIZATION *(Please Read Carefully and Sign)*

The above information is accurate and complete to the best of my knowledge. I understand that it is my responsibility to inform my doctor if there are any changes in my health. I authorize Jespersen & Kim D.D.S., Inc./ Jespersen & Jespersen D.D.S. / AJK Dental to use my healthcare information and may disclose such information to my insurance company (ies) and their agents for the purpose of obtaining payment for services.

Signature: _____ Date Signed: _____/_____/_____ Relationship to Patient: _____

For Office Use ONLY: BP: _____/_____ P: _____ Doctor's Initials: _____ Date: _____

Update Information	Changes in Health History	Patient Signature	Dr.'s Signature
/ /	☐ No changes since my last visit ☐ Yes: Please see changes in RED ink	×	×
/ /	☐ No changes since my last visit ☐ Yes: Please see changes in GREEN ink	×	×
/ /	☐ No changes since my last visit ☐ Yes: Please see changes in BLUE ink	×	×