Patient Registration

Jin Y. Kim, DDS, MPH, MS, FACD
A Professional Corporation
Diplomate, American Board of Periodontology
Diplomate, American Board of Oral Implantology/Implant Dentistry
Diplomate, International Congress of Oral Implantologists
Fellow, American College of Dentists

Patient Information

Name ______________________ Today's Date ____ /____ /____

Address ______________________ Home Phone (   ) ______ - ______

City ______________ State ______ Zip ______ Cell Phone (   ) ______ - ______

Date of Birth ____ /____ /____ Age ______ ☐ Male ☐ Female Work Phone (   ) ______ - ______

Are you: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Primary Number: ☐ Home ☐ Cell ☐ Work

Email ______________________ Social Security No. ______ - ______ - ______

OK to text you for confirming your appointment, etc? ☐ Yes ☐ No

OK to e-mail you for confirming your appointment, etc? ☐ Yes ☐ No

Referral Information

☐ General Dentist ☐ Family/Friend

☐ Dental Specialist ☐ Other Patient

☐ Physician ☐ Internet

Name ______________________

Date of Referral ____ /____ /____ Phone Number (   ) ______ - ______

Address ______________________

City ______________ State ______ Zip ______

Dental Insurance

Insured's Name ______________________ Name of Employer ______________________

Insurance Company ______________________ Group No. ______________________

Insured's I.D. No. ______________________ Insured's Social Security No. ______ - ______ - ______

Relationship to Patient ______________________ Date of Birth ____ /____ /____

Getting to Know You

Is another member of your family a patient at our office?

Name ______________________ Relationship ______________________

Person to Contact in case of an Emergency

Name ______________ Relationship ______________ Phone Number (   ) ______ - ______

Address ______________ City ______________ State ______ Zip ______

Please complete consent on back page

Jin Y. Kim, DDS, MPH, MS
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Shen Ling, DMD, MA
A Professional Corporation

PERIODONTICS DENTAL IMPLANTS
DRS. LING, KIM & ASSOCIATES

MEDICAL HISTORY

Welcome! So that we may provide you with the best possible care please complete this dental history form. All information is completely confidential.

Patient Name:______________________ Date:______ / ______ / ______

1. Have you been under care of a medical doctor during the past two years?________ Yes No
   If yes, for what?________
   Physician's Name________ Phone________
   Address________ City________ State _____ Zip________
2. Have you taken any medication or drugs during the past two years? Yes No
3. Are you taking any medication, drugs or pills now, including regular dosages of aspirin? Yes No
   If yes, please list name and dosage________
4. Have you ever taken prescription medications for weight loss (diet pills)? Yes No
   If yes, did you take any of the following: Yes No Fen-Phen (Fenfluramine-Phentermine)
   Yes No Pondimen (Fenfluramine)
   Yes No Redux (Dexfenfluramine)
   If yes to any of the above, did you have a medical exam for heart issues? Yes No
5. Are you aware of having an allergic **(or adverse)** reaction to any medication or substance? Yes No
   If yes, please list:________
6. Have you been a patient in the hospital during the past five years? Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A. I. D. S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H. I. V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (Hip, Knee, Etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

8. Do you use more than two pillows to sleep? Yes No
9. Have you lost or gained more than 10 pounds in the past year? Yes No
10. Do you have or have you had any disease, condition, or problem not listed? Yes No
    If yes, please list:________
11. **Women** Are you: • **Pregnant?** Yes, Months No • **Nursing?** Yes No • **Taking birth control pills?** 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 change in my health or medication.

Patient/Guardian Signature________________________ Date ____________

History Review

Dentist Signature ________________________ Date ___________

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Dear Patient,

Recent changes in federal law now requires that we provide you with written notification of our privacy policies regarding your health information. Please read the notice and feel free to ask any questions. Please print your name, sign and date this letter below to show you have read the notice. This receipt will be placed in your records here at our office.

Sincerely,

Jin Y. Kim, DDS, MPH, MS, FACD

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Acknowledgement

I have read a copy of "Notice of Privacy Policies" provided by Dr. Jin Y Kim's practice.

Signed ____

Print Name ____

Date ____

If signing as a parent or guardian, please note the name of the patient:

____