DR.SY KIM DDS

1 PATIENT INFORMATION

Date Today _____ *

Social Security # _____ or ID

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age___

Birth Date _____ Marital Status _____

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Spouse's Birth Date _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 DENTAL INSURANCE

Whom is responsible for your office Co Pay? _____ *

Relationship to Patient _____

Insurance Co. _____

Group # _____

Does the patient have 2 dental insurance plans? ☐ Yes ☐ No

Subscriber's Name _____

Birth Date _____ 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)
Sy Kim, DDS, Inc. 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

3 PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____

☐ By selecting this box, you agree to receive SMS messages from Sy Kim DDS, Inc. Message and data rates may apply. Reply STOP to no longer receive messages at any time.

* **IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 DENTAL HISTORY

*Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit * _____

Date of last dental X-rays * _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? * _____

How often do you brush? * _____

* Frequently missed questions

DR.SY KIM DDS

(916)487-5032

OFFICE POLICY

TODAY'S DATE:	FIRST NAME	LAST NAME	BIRTHDAY

Welcome to Sy Kim, DDS, Inc.,

Please read the below explanation of our policies regarding treatments and financial matters.
We believe that service to our patients is at its best when there is complete understanding and mutual cooperation.

1. Payments. The payment is required at the time of dental service.
2. Insurance. I, Me Test the undersigned, have dental insurance coverage with Delta Dental of California and assign directly to Sy Kim, DDS, Inc. all 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.
   Your insurance is a contract between you, your employer and the insurance company.
   Our office is not a party to that contract. Not all services are a covered benefit in all contracts.
   Some insurance companies arbitrarily select certain services they will not cover.
   I hereby authorize the office to release all information necessary to secure the payment of benefits.
   I authorize the use of this signature on all my insurance submissions.
3. Late Charges. If payment are extended 30 days from the date of treatment completion. I agree to pay 1.5% interest per month on the unpaid balance (annual percentage rate 18%).
4. Overdue Account. If an account is past due, we cannot provide any active treatment until the account is brought up to date.
5. Returned Checks. Checks returned for insufficient funds will be subject to a $25 service charge.
6. Credit. In case of overpayment, you will be reimbursed at the end of treatment.
7. Broken Appointments. We realize that once in a while you may have to reschedule the appointment.
   We appreciate receiving a 48 hour notice. And it does not include weekends or holidays. We have reserved the appointment time for you and
   a missed appointment means that our time could have been spent with another patient.
   We will charge you $75 for hygienist appointment and $200 for doctor's appointment for every broken appointment without 48 hour notice prior to your scheduled appointment.
8. Duplication. You are entitled to have duplications of any documents from your own chart. Some duplication may require fees and this process may take up to 10 business days.
9. In the event of a suit or referral to collect, I agree to pay, in addition to the unpaid balance, all attorneys' fees and filing fees of $25, court costs and additional collection fee of $295.00.
10. Credit/Debit Card Processing Fee. I acknowledge that Sy Kim DDS, Inc. shall charge a 3.50% fee for all credit and debit card transactions. We accept checks with no additional fees.
    When using care credit, I acknowledge that there is a 5.90% fee for the 6 month deferment period, 9.90% fee for the 12 month deferment period, and 13.50% fee for the 18 month deferment period.

Signature of Patient/Guardian:

FIRST NAME _____ **LAST NAME:** _____ **BIRTHDAY:** _____

5 HEALTH HISTORY

* **Frequently missed questio**

Medical Doctor * _____ Date of last visit _____

Have you ever taken oral/IV Bisphosphonate for Osteoporosis or cancer treatment? These include Fosamax, Actonel, Prolia, Denosumab, Avastic, or Sutene. ☐ Yes ☐ No *

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
☐ Hip ☐ Knee ☐ Other: _____			Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hepatitis Type_____	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
			Jaundice	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Cancer (Type _____)	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No			
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Other unlisted Disability	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			
			High Cholesterol	☐ Yes	☐ No	Please explain:		

* _____ _____ _____

Patient's Signature Date Doctor's Signature

Women: Are you pregnant? ☐ Yes ☐ No Due Date _____ Are you nursing? ☐ Yes ? ☐ No

Taking birth control pills? ☐ Yes ☐ No
(in case we need to prescribe you antibiotics)

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	_____

6 PRIVACY PRACTICES

As of January 1st, 2012 the Dental Board of California now requires that we show our patients a copy of the Dental Materials Fact Sheet. In addition, the Health Insurance Portability and Accountability Act (HIPPA) requires as of 2003, that patients also be shown a copy of our Notice of Privacy Practice. We would be glad to make you a copy upon request or e-mail it to you. Please sign your name below verifying that you have seen these documents. I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

I,* _____, acknowledge I have seen the Notice of Privacy Practices and the Dental Materials Fact Sheet.

_____

Signature of Patient/Parent/Guardian/Personal Representative

* _____ _____ _____

PRINTED NAME of Patient/Parent/ Guardian/Person Representative | Date | Relationship to Patient

* **Frequently missed questio**