DR.**SYKIM** DDS

PATIENT IN	FORMAT	ION	DENTAL INSURANCE
Z IIIIIEI III		1011	Whom is responsible for your office Co Pay?*
DateToday			Relationship to Patient
Social Security #	or ID		Insurance Co.
Patient Name			Group #
	Last Name		Does the patient have 2 dental insurance plans?
First Name	N	Middle Initial	Subscriber's Name
Address	**		Birth Date SS#
E-mail			Relationship to Patient
			Insurance Co
City		1	Group #
State	Zip		ASSIGNMENT AND RELEASE I certify that I, and/or my dependent(s), have insurance coverage with
Sex ☐M☐F Age			and assign directly to
Birth DateN	1arital Status		Name of Insurance Company(ies)
Patient Employer/School	=		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
Occupation			whether or not paid by Insurance. I authorize the use of my signature on all insurance submissions.
Employer/School Address			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
Employer/School Phone ("	my current treatment plan is completed or one year from the date signed below.
Spouse's Name			
Spouse's Birth Date			Signature of Patient, Parent, Guardian or Personal Representative
SS#			Please print name of Patient, Parent, Guardian or Personal Representative
Spouse's Employer			r lease print name of r attent, r arent, dual dall of r elsonal nepresentative
Whom may we thank for referri			Date Relationship to Patient
<u> </u>			
PHONE NUM	ABERS		
receive messages at any time * IN CASE OF EMERGENCY, C	e. ONTACT (Specify	S messages from Sy Kir	Ext Cell Phone ()_ n DDS, Inc. Message and data rates may apply. Reply STOP to no longer ve in your household.) Relationship
Home Phone ()			Work Phone ()_
Home Home ()_		-	WORKTHOILE ()
DENTAL HIS	STORY		
*Reason for today's visit		Burning sensation on to	ngue Yes No Orthodontic treatment Yes No
		Chew on one side of me	
			smoking ☐ Yes ☐ No Periodontal treatment ☐ Yes ☐ No
Former Dentist		Choking or popping jaw	Yes No Sensitivity to cold
City/State		Dry mouth	☐ Yes ☐ No Sensitivity to heat ☐ Yes ☐ No
Date of last dental visit *		Fingernail biting Food collection between	☐ Yes ☐ No Sensitivity to sweets ☐ Yes ☐ No he teeth ☐ Yes ☐ No Sensitivity when biting ☐ Yes ☐ No
Date of last dental X-rays *		Grinding teeth	Yes No Sores or growths in your mouth Yes No
Place a mark on "yes" or "no" to	indicate if you	Gums swollen or tende Jaw pain or tiredness	☐ Yes ☐ No ☐ How often do you floss?*
have had any of the following: Bad breath	□Yes □No	Lip or cheek biting	Yes No How often do you brush?*
Bleeding gums	Yes No	Loose teeth or broken f	
Blisters on lips or mouth	☐Yes ☐No	Mouth breathing	Yes No * Frequently missed questions

DR.SYKIM DDS

(916)487-5032

OFFICE POLICY

TODAY'S FIRST LAST
DATE NAME 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:

Date of last visit	Date of last visit Date of last visit Date of	Date of last visit	phonate for Osi	teoporosis or cancer treatment ve had any of the following Epilepsy Fainting or dizziness Glaucoma Headaches Heart Murmur Heart Problems Hepatitis Type Herpes High Blood Pressure Jaundice Jaw Pain Kidney Disease Liver Disease Low Blood Pressure Mitral Valve Prolapse Nervous Problems Pacemaker Psychiatric Care	Yes	Ude Fosama No	Date of last visitax, Actonel, Prolia, Denosumab, Respiratory Disease Rheumatic Fever Scarlet Fever Shortness of Breath Sinus Trouble Skin Rash Stroke Swollen Feet or Ankles Swollen Neck Glands Thyroid Problems Tonsillitis Tuberculosis Tumor or growth on head or neck Ulcer Venereal Disease	Avastic, Yes
Have you ever taken oral/IV Bisphosphonate for Osteoporosis or cancer treatment? These include Fosamax, Actonel, Prolia, Denosumab, Avastic, or Sutene.	Ver taken oral/IV Bisphosphonate for Osteoporosis or cancer treatment? These include Fosamax, Actonel, Prolia, Denosumab, Avastic, Ves No	Have you ever taken oral/IV Bisphosphonate for Osteoporosis or cancer treatment? These include Fosamax, Actonel, Prolla, Denosumab, Avastic, or Sulene. Yes No	phonate for Ost Continue Continue Continue	ve had any of the following Epilepsy Fainting or dizziness Glaucoma Headaches Heart Murmur Heart Problems Hepatitis Type Herpes High Blood Pressure Jaundice Jaw Pain Kidney Disease Liver Disease Low Blood Pressure Mitral Valve Prolapse Nervous Problems Pacemaker Psychiatric Care	Yes	No N	Respiratory Disease Rheumatic Fever Scarlet Fever Shortness of Breath Sinus Trouble Skin Rash Stroke Swollen Feet or Ankles Swollen Neck Glands Thyroid Problems Tonsillitis Tuberculosis Tumor or growth on head or neck Ulcer Venereal Disease	Yes
Place a mark on "yes" or "no" to indicate if you have had any of the following: AIDS/HIV	Yes No	Place a mark on "yes" or "no" to indicate if you have had any of the following: AlbS/HIV	dicate if you have feed in No fee	ve had any of the following Epilepsy Fainting or dizziness Glaucoma Headaches Heart Murmur Heart Problems Hepatitis Type Herpes High Blood Pressure Jaundice Jaw Pain Kidney Disease Liver Disease Low Blood Pressure Mitral Valve Prolapse Nervous Problems Pacemaker Psychiatric Care	Yes	No	Respiratory Disease Rheumatic Fever Scarlet Fever Shortness of Breath Sinus Trouble Skin Rash Stroke Swollen Feet or Ankles Swollen Neck Glands Thyroid Problems Tonsillitis Tuberculosis Tumor or growth on head or neck Ulcer Venereal Disease	Yes N Yes
AlDS/HIV	Yes No Epilepsy Yes No Respiratory Disease Yes No Scarlet Fever Yes No No Storke Yes No No No Storke Yes No No Storke Yes No No No Storke Yes No No No No No No No N	Albert Ves No Epilepsy Yes No Respiratory Disease Yes Anemia Yes No Fainting or dizziness Yes No Rheumatic Fever Yes Arthritis, Rheumatism Yes No Glaucoma Yes No Scarlet Fever Yes Arthritis, Rheumatism Yes No Headaches Yes No Scarlet Fever Yes Arthritidial Heart Valves Yes No Headaches Yes No Shortness of Breath Yes Arthritidial Joints Yes No Heart Murmur Yes No Sinus Trouble Yes Arthritidial Joints Yes No Heart Murmur Yes No Skin Rash Yes No Asthma Yes No Heart Problems Yes No Skin Rash Yes No Satch Problems Yes No Stroke Yes No Tonsillitis Yes Tonsillitis Yes Tonsillitis Yes Tonsillitis Yes Tonsillitis Yes No Tonsillitis Yes Tonsillitis Yes Tonsillitis Yes No No Tonsillitis Yes No No Tonsillitis Yes No No Tonsillitis Tonsillitis Yes No No Tonsillitis Tonsillitis Tonsillitis	Yes No	Epilepsy Fainting or dizziness Glaucoma Headaches Heart Murmur Heart Problems Hepatitis Type Herpes High Blood Pressure Jaundice Jaw Pain Kidney Disease Liver Disease Low Blood Pressure Mitral Valve Prolapse Nervous Problems Pacemaker Psychiatric Care	☐ Yes	No	Rheumatic Fever Scarlet Fever Shortness of Breath Sinus Trouble Skin Rash Stroke Swollen Feet or Ankles Swollen Neck Glands Thyroid Problems Tonsillitis Tuberculosis Tumor or growth on head or neck Ulcer Venereal Disease	Yes
Anemia	Yes	Anemia	Yes No	Fainting or dizziness Glaucoma Headaches Heart Murmur Heart Problems Hepatitis Type Herpes High Blood Pressure Jaundice Jaw Pain Kidney Disease Liver Disease Low Blood Pressure Mitral Valve Prolapse Nervous Problems Pacemaker Psychiatric Care	☐ Yes	No	Rheumatic Fever Scarlet Fever Shortness of Breath Sinus Trouble Skin Rash Stroke Swollen Feet or Ankles Swollen Neck Glands Thyroid Problems Tonsillitis Tuberculosis Tumor or growth on head or neck Ulcer Venereal Disease	Yes
Arthritis, Rheumatism	Reumatism	Arthritis, Rheumatism	Yes No	Glaucoma Headaches Heart Murmur Heart Problems Hepatitis Type Herpes High Blood Pressure Jaundice Jaw Pain Kidney Disease Liver Disease Low Blood Pressure Mitral Valve Prolapse Nervous Problems Pacemaker Psychiatric Care	☐ Yes	No	Scarlet Fever Shortness of Breath Sinus Trouble Skin Rash Stroke Swollen Feet or Ankles Swollen Neck Glands Thyroid Problems Tonsillitis Tuberculosis Tumor or growth on head or neck Ulcer Venereal Disease	Yes
Artificial Heart Valves	Art Valves	Artificial Heart Valves	res No	Headaches Heart Murmur Heart Problems Hepatitis Type Herpes High Blood Pressure Jaundice Jaw Pain Kidney Disease Liver Disease Low Blood Pressure Mitral Valve Prolapse Nervous Problems Pacemaker Psychiatric Care	☐ Yes	No	Shortness of Breath Sinus Trouble Skin Rash Stroke Swollen Feet or Ankles Swollen Neck Glands Thyroid Problems Tonsillitis Tuberculosis Tumor or growth on head or neck Ulcer Venereal Disease	Yes N
Artificial Joints	No Heart Murmur Yes No Sinus Trouble Yes No Sinus Trouble Yes No Skin Rash Yes No No Skin Rash Yes No No Skin Rash Yes No No No No No No No N	Artificial Joints Yes No	Yes No	Heart Murmur Heart Problems Hepatitis Type Herpes High Blood Pressure Jaundice Jaw Pain Kidney Disease Liver Disease Low Blood Pressure Mitral Valve Prolapse Nervous Problems Pacemaker Psychiatric Care	☐ Yes	No	Sinus Trouble Skin Rash Stroke Swollen Feet or Ankles Swollen Neck Glands Thyroid Problems Tonsillitis Tuberculosis Tumor or growth on head or neck Ulcer Venereal Disease	☐ Yes ☐ N
Hip Knee Other:	Knee Other:	Hip Knee Other:	res No	Heart Problems Hepatitis Type Herpes High Blood Pressure Jaundice Jaw Pain Kidney Disease Liver Disease Low Blood Pressure Mitral Valve Prolapse Nervous Problems Pacemaker Psychiatric Care	☐ Yes	No	Skin Rash Stroke Swollen Feet or Ankles Swollen Neck Glands Thyroid Problems Tonsillitis Tuberculosis Tumor or growth on head or neck Ulcer Venereal Disease	□ Yes □ N
Asthma	Yes	Asthma	res No	Hepatitis Type Herpes High Blood Pressure Jaundice Jaw Pain Kidney Disease Liver Disease Low Blood Pressure Mitral Valve Prolapse Nervous Problems Pacemaker Psychiatric Care	☐ Yes	No	Stroke Swollen Feet or Ankles Swollen Neck Glands Thyroid Problems Tonsillitis Tuberculosis Tumor or growth on head or neck Ulcer Venereal Disease	□ Yes □ N
Asthma	Yes	Asthma Yes No Hepatitis Type Yes No Stroke Yes Stroke Yes Stroke Yes Stroke Yes Stroke Yes No Swollen Feet or Ankles Yes Stroke Yes Stroke Yes No Swollen Neck Glands Yes Yes No Thyroid Problems Yes No Thyroid Problems Yes No Thyroid Problems Yes No Tuberculosis Yes No Tuberculosis Yes No Ornsellitis Orn	res No	Hepatitis Type Herpes High Blood Pressure Jaundice Jaw Pain Kidney Disease Liver Disease Low Blood Pressure Mitral Valve Prolapse Nervous Problems Pacemaker Psychiatric Care	☐ Yes	No	Swollen Feet or Ankles Swollen Neck Glands Thyroid Problems Tonsillitis Tuberculosis Tumor or growth on head or neck Ulcer Venereal Disease	☐ Yes ☐ N
Back Problems Yes No	Are you pregnant? Patient's Signature Patient's S	Sack Problems	Yes No	High Blood Pressure Jaundice Jaw Pain Kidney Disease Liver Disease Low Blood Pressure Mitral Valve Prolapse Nervous Problems Pacemaker Psychiatric Care	☐ Yes	NoNoNoNoNoNoNoNoNo	Swollen Neck Glands Thyroid Problems Tonsillitis Tuberculosis Tumor or growth on head or neck Ulcer Venereal Disease	☐ Yes ☐ N
Section of Surgery Jaundice Yes No Thyroid Problems Yes No Thyroid Problems Yes No Thyroid Problems Yes No Thyroid Problems Yes No Tonsillitis Yes No Tuberculosis Yes No Yes No Norword Prossure Yes No Norword Prossure Yes No Vereinal Disease Yes No Vereinal Disease Yes No Yes No Yes Yes No Yes Yes No Yes No Yes No Yes No Yes No Yes No Yes Yes Yes No Yes Yes No Yes Yes No Ye	Jaundice Yes No Thyroid Problems Yes No Tosillitis Yes No Tosillitis Yes No Tuberculosis Yes No Tuberculosis Yes No Tuberculosis Yes No Tumor or growth on head Yes No Yes No Tumor or growth on head Yes No Yes No No Nor Nor	Jaundice Yes No Thyroid Problems Yes Slood Disease Yes No Jaw Pain Yes No Tonsillitis Yes Slood Disease Yes No Kidney Disease Yes No Tonsillitis Yes Slood Disease Yes No Kidney Disease Yes No Tuberculosis Yes Slood Disease Yes Slood Disease Yes No Tuberculosis Yes Slood Disease Yes No Tuberculosis Yes Slood Disease Yes Slood Disease Yes No Tuberculosis Yes Slood Disease Yes Slood Disease Yes Slood Disease Yes No Tuberculosis Yes Slood Disease Yes S	rées No	Jaundice Jaw Pain Kidney Disease Liver Disease Low Blood Pressure Mitral Valve Prolapse Nervous Problems Pacemaker Psychiatric Care	☐ Yes	□ No	Thyroid Problems Tonsillitis Tuberculosis Tumor or growth on head or neck Ulcer Venereal Disease	☐ Yes ☐ N
Stood Disease Yes No No No Thyroid Problems Yes No Thyroid Problems Yes No Tonsillitis Yes No Tuberculosis Yes No Tuberculosis Yes No Tuberculosis Yes No Tumor or growth on head Yes No Nemotherapy Yes No No Nemotherapy Yes No Nemotherapy Yes No Nervous Problems Yes No Venereal Disease Yes Yes No Nervous Problems Yes No Nemotherapy Yes No Nervous Problems Yes No Nemotherapy Y	So or surgery Jaundice Yes No Thyroid Problems Yes No No Thyroid Problems Yes No No No No No No No N	Stractions or surgery	Yes No	Jaw Pain Kidney Disease Liver Disease Low Blood Pressure Mitral Valve Prolapse Nervous Problems Pacemaker Psychiatric Care	☐ Yes	□ No □ No □ No □ No □ No □ No	Tonsillitis Tuberculosis Tumor or growth on head or neck Ulcer Venereal Disease	☐ Yes ☐ N ☐ Yes ☐ N ☐ Yes ☐ N ☐ Yes ☐ N
Cancer (Type)	De	Cancer (Type)	Yes No	Kidney Disease Liver Disease Low Blood Pressure Mitral Valve Prolapse Nervous Problems Pacemaker Psychiatric Care	☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes	□ No □ No □ No □ No	Tuberculosis Tumor or growth on head or neck Ulcer Venereal Disease	☐ Yes ☐ N ☐ Yes ☐ N ☐ Yes ☐ N
Chemical Dependency	rependency Yes No	Chemical Dependency Yes No Liver Disease Yes No Tumor or growth on head Yes Chemotherapy Yes No Low Blood Pressure Yes No Ulcer Yes Chemotherapy Yes No Mitral Valve Prolapse Yes No Ulcer Yes Chemotherapy Yes No Mitral Valve Prolapse Yes No Venereal Disease Yes Chemotherapy Yes No Nervous Problems Yes No Venereal Disease Yes Chemotherapy Yes No Nervous Problems Yes No Venereal Disease Yes Chemotherapy Yes No Nervous Problems Negative Problems Yes No Nervous Problems Yes No Nervous Problems No Nervous Problems Negative Problems	/es □ No	Liver Disease Low Blood Pressure Mitral Valve Prolapse Nervous Problems Pacemaker Psychiatric Care	□ Yes □ Yes □ Yes	□ No □ No □ No	Tumor or growth on head or neck Ulcer Venereal Disease	□Yes □N
Chemotherapy	Apy	Chemotherapy Yes No Low Blood Pressure Yes No Or neck Ulcer Yes Congenital Heart Lesions Yes No Mitral Valve Prolapse Yes No Venereal Disease Yes Cough, persistent or bloody Yes No Pacemaker Yes No Weight Loss, unexplained Yes Diabetes Yes No Pacemaker Yes No Other unlisted Disability Yes Diabetes Yes No Padiation Treatment Yes No Please explain: Patient's Signature Date Doctor's Signature Women: Are you pregnant? Yes No Due Date Are you nursing? Yes ? No MEDICATIONS ALLERGIES ist any medications you are currently taking and the correlating diagnosis: Barbiturates (Sleeping pills) Penicillin	res □ No	Low Blood Pressure Mitral Valve Prolapse Nervous Problems Pacemaker Psychiatric Care	□ Yes □ Yes □ Yes	□ No	or neck Ulcer Venereal Disease	□Yes □N
Congenital Heart Lesions Yes No Nitral Valve Prolapse Yes No Venereal Disease Yes Yes No Venereal Disease Yes Yes	Heart Lesions Yes No Mitral Valve Prolapse Yes No Venereal Disease Yes No Other unlisted Disability Yes No No No No No No No N	Congenital Heart Lesions Yes No Mitral Valve Prolapse Yes No Venereal Disease Yes Congenital Heart Lesions Yes No Nervous Problems Yes No Venereal Disease Yes No Other unlisted Disability Yes Indicate Yes No No Yes	res □ No	Mitral Valve Prolapse Nervous Problems Pacemaker Psychiatric Care	□ Yes □ Yes	□No	Ulcer Venereal Disease	
Patient's Signature	Heart Lesions	Conginential Heart Lesions Yes No Mitral Valve Prolapse Yes No Venereal Disease Yes Corrisone Treatments Yes No Nervous Problems Yes No Venereal Disease Yes Weight Loss, unexplained Yes Diabetes Yes No Pacemaker Yes No Other unlisted Disability Yes Diabetes Yes No Percentage Yes	res □ No res □ No res □ No	Nervous Problems Pacemaker Psychiatric Care	□Yes		Venereal Disease	
Cough, persistent or bloody	reatments	Cough, persistent or bloody Yes No Nervous Problems Yes No Weight Loss, unexplained Yes Diabetes Yes No Pacemaker Yes No Other unlisted Disability Yes Diabetes Yes No Pacemaker Yes No Other unlisted Disability Yes Diabetes Yes No Persistent or bloody Yes No No Persistent or bloody Yes No Persistent or bloody	′es □ No ′es □ No	Pacemaker Psychiatric Care		☐ No		
Patient's Signature Patient's Signature Diabetes Patient's Signature Patient's Signature Date Doctor's Signature Patient service of bloody Pacemaker No Other unlisted Disability Pacemaker Pacemaker	Patient's Signature Patient's Signature Date Doctor's Signature Are you pregnant? Taking birth control pills? (in case we need to prescribe you antibiotics) Pacemaker Pacemaker Yes No Yes No Other unlisted Disability Please explain: Please explain: Patient's Signature Are you pregnant? Taking birth control pills? (in case we need to prescribe you antibiotics) ALLERGIES	Patient's Signature	′es □ No	Psychiatric Care	□Yes		Weight Loss unavalained	= = -
Diabetes	Patient's Signature Are you pregnant? Taking birth control pills? (in case we need to prescribe you antibiotics) Psychiatric Care Yes No Please explain: Yes No Please explain: Patient's Signature Doctor's Signature Are you nursing? Yes? No ALLERGIES	Patient's Signature Patient's Signature Date Doctor's Signature Date Doctor's Signature Patient's Signature Date Doctor's Signature Doctor's Signature Are you pregnant? Taking birth control pills? (In case we need to prescribe you artibiotics) MEDICATIONS Sist any medications you are currently taking and the correlating diagnosis: Aspirin		•		☐ No	• .	
High Cholesterol	High Cholesterol High Cholesterol High Cholesterol Yes □ No Patient's Signature Date Doctor's Signature Are you pregnant? Taking birth control pills? (in case we need to prescribe you antibiotics) MEDICATIONS ALLERGIES	High Cholesterol Yes No No No No No No No N	′es ∐No		□Yes	□No	,	
Patient's Signature Date Doctor's Signature Women: Are you pregnant?	Patient's Signature Are you pregnant?	Patient's Signature		High Cholesterol			Please explain:	
Women: Are you pregnant? ☐ Yes ☐ No ☐ Due Date Are you nursing? ☐ Yes? ☐ No Taking birth control pills? (in case we need to prescribe you antibiotics) Yes ☐ No	Are you pregnant?	Women: Are you pregnant?		· · · · · · · · · · · · · · · · · · ·			Doctor's Sign	nature
Taking birth control pills? Yes No (in case we need to prescribe you antibiotics)	Taking birth control pills?	Taking birth control pills?						
	MEDICATIONS ALLERGIES	MEDICATIONS ist any medications you are currently taking and the correlating diagnosis: Aspirin	ills?				Are you harsing: Life's	140
MEDICATIONS ALLERGIES	fications you are currently taking and the correlating diagnosis: Aspirin Local Anesthetic	Barbiturates (Sleeping pills) Penicillin Codeine Sulfa I lodine Other Latex		S			ALLERGIES	
ist any medications you are currently taking and the correlating diagnosis: Aspirin Local Anesthetic		charmacy Name Codeine Sulfa	y taking and the	e correlating diagnosis:	☐ Aspirin		☐ Local Anesthe	etic
□ Barbiturates (Sleeping pills) □ Penicillin	☐ Barbiturates (Sleeping pills) ☐ Penicillin	Codeine			☐ Barbiturate	es (Sleeping	g pills)	
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	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	PRIVACY PRACTICES ary 1st, 2012 the Dental Board of California now requires that we show our patients a copy of the Dental Materials Fact Sheet. In addition							
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 the Health Insurance Portability and Accountability Act (HIPPA) requires as of 2003, that patients also be shown a copy of our Notice of Private.	PRIVACY PRACTICES ary 1st, 2012 the Dental Board of California now requires that we show our patients a copy of the Dental Materials Fact Sheet. In addition Insurance Portability and Accountability Act (HIPPA) requires as of 2003, that patients also be shown a copy of our Notice of Privacy	he Health Insurance Portability and Accountability Act (HIPPA) requires as of 2003, that patients also be shown a copy of our Notice of Privacy			•			
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 the Health Insurance Portability and Accountability Act (HIPPA) requires as of 2003, that patients also be shown a copy of our Notice of Privaractice. 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	PRIVACY PRACTICES ary 1st, 2012 the Dental Board of California now requires that we show our patients a copy of the Dental Materials Fact Sheet. In addition Insurance Portability and Accountability Act (HIPPA) requires as of 2003, that patients also be shown a copy of our Notice of Privacy 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	ne Health Insurance Portability and Accountability Act (HIPPA) requires as of 2003, that patients also be shown a copy of our Notice of Privacy ractice. 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						
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Date

Frequently missed questio

PRINTED NAME of Patient/Parent/ Guardian/Person Representative