Tyler Kim DDS & Tat Chiang DMD

10 N. Gaston Ave Somerville, NJ 08876 P: 908-218-0770 F: 908-218-9789 E: smile@kandcperio.com

(I) Patient Information

Name: Last First Title:	DOB: Sex: ▢ F ▢ M Marital Status:
Address: City: State: Zip:	Home #: Work #: Cell #: Email:
Employer: Occupation:	General Dentist: Dr.
Social Security #:	Referred by:

(II) Dental Insurance Information (Only dental insurance covers our services.)

PRIMARY DENTAL INSURANCE **Name of the Insured**: Last First	**SECONDARY DENTAL INSURANCE** **Name of the Insured**: Last First
SS # of the **Insured**: ID #	SS # of the **Insured** : ID #
Birthday of the **Insured**:	Birthday of the **Insured**:
Relationship to the insured:	Relationship to the insured:
Employer of the Insured or Plan Name:	Employer of the Insured or Plan Name:
Dental Insurance Company Name: Group ID:	**Dental Insurance Company** Name: Group ID:
Address:	Address:
Phone #:	Phone #:

(III) Dental Health Information

How can we help you today? ____

Have you had any serious trouble associated with any previous dental treatment?

____

Is there anything we should know about your dental concerns?

____

Initial: _________

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(IV) Health Information

☐ Y ☐ N	**1.** Are you in good health?
☐ Y ☐ N	**2.** Has there been any change in your general health within the past year?
☐ Y ☐ N	**3.** Date of your last physical exam
☐ Y ☐ N	**4.** Are you under the care of a physician? **5.** If "yes", what is the condition being treated? ______________________________________ Name of physician: Dr:__________________ Phone #: __________________
☐ Y ☐ N	**6.** Have you had any serious illness or operation? If "yes", what was the illness or operation? _______________ When
☐ Y ☐ N	**7.** Have you been hospitalized or had serious illness within the past 5 years? If "yes", what is the condition being treated?__________________________________
☐ Y ☐ N	**8.** Do you need to be pre-medicated prior to dental treatment?

	9. Woman
☐ Y ☐ N	(A) Are you pregnant?
☐ Y ☐ N	(B) Do you have any problems associated with your menstrual period?
☐ Y ☐ N	(C) Are you nursing?
☐ Y ☐ N	(D) Are you on oral contraceptive? *** Please be advised, we may prescribe antibiotics for your treatment. Antibiotics makes birth control pills ineffective.

Have you ever had any of the following? Please check those that apply.

- ☐ AIDS, HIV
- ☐ Anemia
- ☐ Angina or Chest Pain
- ☐ Arthritis
- ☐ Artificial or Damaged Heart Valves
- ☐ Artificial Joints
- ☐ Asthma or Hay Fever
- ☐ Blood Transfusion
- ☐ Cancer, Tumor
- ☐ Chemotherapy
- ☐ Congenital Heart Lesions
- ☐ Diabetes
- ☐ Dry Mouth
- ☐ Epilepsy
- ☐ Excessive or Abnormal Bleeding
- ☐ Fainting or Seizures
- ☐ Headaches
- ☐ Heart or Cardiovascular Disease
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ High Blood Pressure
- ☐ Hives or Skin Rash
- ☐ Immuno-Suppressive Disorder
- ☐ Kidney Disease
- ☐ Low Blood Pressure
- ☐ Nervous/Psychiatric Disorder
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Stomach Ulcers or Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Other____________________________

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Are you taking any of the following medications? Please check and list those that apply.

- ☐ Antibiotics or sulfite drugs____
- ☐ Anticoagulants (blood thinners) ____
- ☐ Antihistamines
- ☐ Aspirin
- ☐ Cortisone (Steroids)
- ☐ Digitalis or drugs for heart trouble
- ☐ High Blood Pressure medications ____
- ☐ Hormonal Therapy
- ☐ Insulin, Tolbutamide (Orinase) or similar drugs
- ☐ Nitroglycerin
- ☐ Osteoporosis drugs (ex. Fosamax)
- ☐ Tranquilizers
- ☐ Other over-the-counter or prescription medications?

____

Are you allergic to or have reacted adversely to any of the following?

- ☐ Aspirin
- ☐ Barbiturate, sedative or sleeping pills
- ☐ Codeine or other narcotics
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Penicillin or other antibiotics
- ☐ Sulfite Drugs
- ☐ Others

____

I certify that I have read and understand the above. The above information is accurate and complete to the best of my knowledge. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will **notify** my dentist (periodontist) if there is any change to the above. I will not hold my dentist or any member of his/her staff responsible for any errors or emissions that I may have made in the completion of this form. As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. To the extent permitted by law, I consent to use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to dental office of the dental benefits otherwise payable to me.

I understand that the fee estimate listed for this dental care can only be extended for a period of 1 year from the date of the patient examination.
I have read the above conditions of treatment and payment and agree to their content.

NAME: ______________________

____
Signature of patient (Guardian signature for minor)

Date: ____________________

Initial: _________