Patient Registration

❖ About You

Name: ______________________________ Today's Date: ____________________

I like to be called: _______________________ Date of Birth: ____________________

Social Security #: _______________________ Driver's License #: _________________

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other, Spouse's Name: ____________

Employer: ____________________________ Occupation: ____________________

Whom may we thank for referring you? _______________________________________

Special Interests or Hobbies: ____

❖ Contact Information

Home Address: ________________________ City, State, & Zip: _________________

Home Phone: __________________________ Work Phone: ____________________

Email: ______________________________ Cell Phone: ____________________

In case of an emergency, who may we contact on your behalf?

Name: ______________________________ Phone: ________________________

❖ Responsible Party Information

(Please fill out if different from above)

Name: ______________________________ Relation to Patient: ________________

Social Security #: _______________________ Driver's Lic. #: ___________________

Home Phone: __________________________ Work Phone: ____________________

Home Address: ________________________ City, State, & Zip: ________________

❖ Insurance Information

Primary Dental Insurance:

Name of Insured: _______________________ Relation to patient: ________________

Insured's Birth Date: _____________________ Insured's SSN: __________________

Insured's Employer: ______________________ Group/policy #: __________________

Insurance Plan Name: ____________________ Insurance Phone #: ________________

Insurance Address: ____

Additional Dental Insurance

Name of Insured: _______________________ Relation to patient: ________________

Insured's Birth Date: _____________________ Insured's SSN: __________________

Insured's Employer: ______________________ Group/policy #: __________________

Insurance Plan Name: ____________________ Insurance Phone #: ________________

Insurance Address: ____

Office Policy/Financial Responsibility Statement

1. I verify and understand that I am fully responsible for the fees and charges from my dental services provided by Dr. Dennis Baik whether they are paid by my insurance or not.

2. Full payment or ***estimated*** co-payment of insurance is due at the time of the services.

3. It is my responsibility to inform the office of Dr. Dennis Baik if there is a change in my insurance status.

4. I understand that the office of Dr. Dennis Baik reserves the right to charge for duplicating and sending any dental records (including digital records such as dental x-rays) to me or to other healthcare providers whom I designate.

5. If after 90 days the insurance carrier had not paid a claim, it will then be my responsibility to pay the balance to Dennis Baik, DDS and collect from the insurance carrier directly.

6. I understand that as a **courtesy,** office of Dennis Baik, DDS will process my insurance claims. Nevertheless, I am fully aware that I am ultimately responsible for any portions not covered by my insurance

7. I will give at least 48 hours advance notice to the office of Dennis Baik, DDS for any cancellation or changes to my appointment.

Our office reserves the right to charge for appointments cancelled or broken without a full 48 hours advance notice.

8. **ASSIGNMENT AND RELEASE OF INSURANCE BENEFIT**

I certify that I, and/or my dependent(s), have dental insurance coverage with

____ and assign directly to Dr. Dennis Baik all
Name of Insurance company(ies)

insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I further authorize Dr. Baik to disclose my health care 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.

Name of Patient (Print):____

Name of Responsible Party: ___________________________________ ____________________
Relationship to Patient

Signature of Responsible Party:__________________________________ Date:________________

Medical and Dental History

❖ Health Information

Name:______________________________________ Age: _________________ ☐ Male ☐ Female

Name of Personal Physician: ____________________ Physician's Phone #: _________________________

Date of Last Medical visit: ______________________ Current Health: ☐Excellent ☐Good Fair Poor

<u>Please check 'yes ' or "no" to indicate which of the following conditions you have had or currently have</u>

	Yes	**No**		**Yes**	**No**		**Yes**	**No**
AIDS/HIV	☐	☐	Diabetes	☐	☐	Latex Allergy	☐	☐
Allergies	☐	☐	Dizziness/Fainting	☐	☐	Liver Disease	☐	☐
If yes, what?________________			Emphysema	☐	☐	Low Blood Pressure	☐	☐
Anemia	☐	☐	Excessive Bleeding	☐	☐	Nervous Disorder	☐	☐
Arthritis/Rhematism	☐	☐	Epilepsy (Seizure)	☐	☐	Pacemaker	☐	☐
Artificial Heart Valves	☐	☐	Glaucoma	☐	☐	Psychiatric Care	☐	☐
Artificial Joint	☐	☐	Growths/Tumor	☐	☐	Radiation treatment	☐	☐
Asthma	☐	☐	Heart Disease	☐	☐	Respiratory Problem	☐	☐
Blood Disease	☐	☐	Heart Murmur	☐	☐	Shortness of Breath	☐	☐
Cancer	☐	☐	Heart Transplantation	☐	☐	Sinus Problems	☐	☐
Chemical Dependency	☐	☐	Hepatitis Type______	☐	☐	Stroke	☐	☐
Congentl Heart Disease	☐	☐	Herpes	☐	☐	Tuberculosis	☐	☐
(Unrepaired cyanotic)			High Blood Pressure	☐	☐	Taken Fen-Phen ?	☐	☐
Currently Pregnant?	☐	☐	Infective Endocarditis	☐	☐	Taken Bisphosphonates?	☐	☐
If yes, due date:_______________			Jaundice	☐	☐	(e.g. Fosamax, Actonel, or Didronel)		
Currently nursing?	☐	☐	Kidney Disease	☐	☐	Ulcers/Stomach Prob.	☐	☐

- Do you have any medical conditions not listed above? ☐ Yes ☐ No

If yes, please explain: ____

- Are you taking any medications (including herbal)? ☐ Yes ☐No

If yes, please list:____

- Are you allergic to any medications? ☐ Yes ☐No

If yes, please list:____

- Have you been hospitalized within last two years? ☐ Yes ☐ No

If yes, please explain:____

- Do you smoke or use chewing tobacco? ☐ Yes ☐ No, If yes, how much?____
- Have you ever been diagnosed with **O**bstructive **S**leep **A**pnea? Yes No
- Has anyone complained about your snoring? Yes No
- Do you often feel tired, fatigued, or sleepy during daytime? Yes No
- Has anyone observed you stop breathing during your sleep? Yes No

Patient Initial ____________

❖ Dental History

Reason for today's visit: ____

Former Dentist:_________________________________ City/state:_______________________________________

Date of last dental visit__________________________ Reason for the visit:______________________________

*Indicate which of the following you have at present. Check **"yes"** or **"no"** to each item*:

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

How often do you floss?________________________ How often do you brush?______________________

Have you ever had any complications following dental treatment? ☐Yes ☐No

If yes, please explain:____

Please RANK the following in the order of what would PREVENT YOU from receiving proper dental treatment

______FEAR ______ COST _____LACK of concern _____ MISSING work time

❖ Smile Evaluation

*Please check "**yes**" or "**no**" to each item in order to evaluate your smile:*

	Yes	No		Yes	No
Are there any aspects of your smile that you are not happy about?	☐	☐	Do you have any spaces between your teeth that you don't like?	☐	☐
Would you like to change the color of your teeth?	☐	☐	Are any of your teeth chipped/cracked?	☐	☐
Do you have any concerns about the alignment/shape of your teeth?	☐	☐	Do you have fillings or dental work that you don't like looking at?	☐	☐

If you answered yes to any of above questions, please explain____

____

The preceding information is correct to the best of my knowledge. I understand it will be held in the strictest of confidence and only be used to improve communication between Dr.Baik and myself. I also authorize Dr.Baik to contact my family physician and/ or my other medical specialist that I have listed above to obtain further medical information, if necessary.

Patient Signature:____ **Today's Date:**_____________________

Dr. Signature:____ **Today's Date:**_____________________

Updated: 2014-09-11