Modern Dental Center of Sterling -REGISTRATION and HISTORY

①PATIENT INFORMATION

Name________________________________Date______________SS#________________________

Home Address____

Birth date____________________________Age_______________Sex: M F

Occupation__________________________________ Employer____________________________

Employer Address____

Whom may we thank for referring you?

②PHONE NUMBERS

Home Phone____________________Work Phone__________________Cell Phone____________________

Spouse's Name______________________________Spouse's Work Phone____________________________

E-mail ___________________________Would you like to receive appointment reminders via e-mail? ☐ Yes ☐ No

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

Name_______________________________________Relationship___________________________________

Home # Work # Cell#

③DENTAL INSURANCE

Who is responsible for this account?____

Relationship to Patient________________________Insurance Company___________________________

Group #____ID#______________________________________

Subscriber's name___________________________Birth date__________________SS#__________________

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________ and assign directly to Dr. Kim 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 hereby authorize Dr. Kim to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____ ____________________________

responsible party signature date

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relationship to patient

④DENTAL HISTORY

Reason for today's visit____

Former Dentist________________________________City/State__________________________________

Date of last dental visit______________________Date of last dental x-ray______________________

Please **CIRCLE** any of the following symptoms that apply to you:

Bad breath.	Fingernail biting.	Lip or cheek biting.	Smoking/chewing tobacco.
Bleeding gums.	Food collection b/t teeth.	Loose teeth/broken fillings.	Sores in mouth.
Blisters on lips on mouth.	Foreign objects.	Mouth pain.	How often do you floss?
Burning sensation on tongue.	Grinding teeth.	Orthodontic treatment.	____________________
Chew only on one side.	Gums swollen.	Sensitivity to cold.	How often do you brush?
Clicking or popping jaw.	Implant treatment.	Sensitivity to heat.	____________________
Dry Mouth.	Jaw pain.	Sensitivity to sweets.	

⑤HEALTH HISTORY

Physician's Name________________________________ Date of last visit____________________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐Yes ☐No

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

Condition	Yes	No
AIDS/HIV	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No
Bleeding abnormally	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No
Cough, persistent/bloody	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Do you wear contacts?	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No

Condition	Yes	No
Glaucoma	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No
Hepatitis Type	☐ Yes	☐ No
Herpes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Jaw Pain	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Nervous Problems	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Radiation Treatment	☐ Yes	☐ No
Respiratory Disease	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Scarlet fever	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No

Condition	Yes	No
Sinus Trouble	☐ Yes	☐ No
Skin Rash	☐ Yes	☐ No
Special Diet	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Swollen Feet or Ankles	☐ Yes	☐ No
Swollen neck Glands	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Tonsillitis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Tumor of head or neck	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No
Venereal disease	☐ Yes	☐ No
Weight Loss, unexplained	☐ Yes	☐ No

Women:

Question	Yes	No
Are you pregnant?	☐ Yes	☐ No
Taking birth control pills?	☐ Yes	☐ No

Pregnancy due date.________________

⑥MEDICATIONS

List any medications you are currently taking.

Bisphosphonates (Fosamax, Actonel, Boniva, Skelid, Didronel) ☐ Yes ☐ No

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Pharmacy Name______________________________

Phone #___________________________________

⑦ALLERGIES

Please **CIRCLE** any that apply.

Aspirin

Local Anesthetic

Barbiturates

Penicillin

Codeine

Sulfa

Iodine

Other________________

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Latex

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