

PATIENT INFORMATION AND HEALTH HISTORY

INITIAL EXAM

Date _____

PATIENT'S NAME _____ SEX: M F DATE OF BIRTH _____

PATIENT'S ADDRESS _____ STREET _____ CITY _____ STATE _____ ZIP _____ PATIENT'S PHONE _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RESIDENCE PHONE _____

RESIDENCE ADDRESS _____

EMPLOYED BY _____ BUSINESS PHONE _____

BUSINESS ADDRESS _____ PATIENT'S SS# _____

SPOUSE'S NAME _____

DENTAL INSURANCE PLAN (IF ANY) _____ REFERRED BY _____

PATIENT'S NAME

DENTAL HISTORY

CHIEF ORAL COMPLAINT _____

DATE OF LAST DENTAL EXAM. _____ ANY PREVIOUS MAJOR DENTAL TREATMENT, YES NO WHEN _____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING — INDICATE WITH A (✓)

- | | | |
|--|---|--|
| <input type="checkbox"/> Teeth sensitive to cold, heat, sweets or pressure | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Cigarettes, pipe or cigar smoking |
| <input type="checkbox"/> Bleeding gums. How long _____ | <input type="checkbox"/> Unpleasant taste | <input type="checkbox"/> Texture of toothbrush _____ |
| <input type="checkbox"/> Food impaction | <input type="checkbox"/> Unfavorable dental experience | <input type="checkbox"/> Frequency of brushing _____ |
| <input type="checkbox"/> Clenching or grinding | <input type="checkbox"/> Complications from extractions | <input type="checkbox"/> Dental Floss |
| <input type="checkbox"/> Burning of tongue | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Inter dental stimulators |
| <input type="checkbox"/> Swelling or lumps in mouth | <input type="checkbox"/> Orthodontic treatment | <input type="checkbox"/> Water jet device |
| <input type="checkbox"/> Frequent blisters on lips or mouth | <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> Disclosing tablets or solution |
| <input type="checkbox"/> Pain around ear | <input type="checkbox"/> Oral habits, i.e., fingernail biting | <input type="checkbox"/> Fluoride supplements |
| <input type="checkbox"/> Unusual sounds in ear while eating | <input type="checkbox"/> cheek biting, etc. | <input type="checkbox"/> Allergic to Dental anesthetics (novocain) |

MEDICAL HISTORY

PHYSICIAN'S NAME _____ DATE OF LAST PHYSICAL EXAM. _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING — INDICATE WITH A (✓)

- | | | |
|--|--|---|
| <input type="checkbox"/> Allergies to drugs (List) _____ | <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies to anesthetics | <input type="checkbox"/> Hay fever or allergies in general | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Any heart ailments | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eye disorders |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Liver problems or hepatitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Radiation treatments | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Ulcer or colitis |
| <input type="checkbox"/> Excessive bleeding from cut or extraction | <input type="checkbox"/> Psychiatric care/emotional problems | <input type="checkbox"/> Pregnancy — what month _____ |
| <input type="checkbox"/> Anemia or blood problems | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Veneral Disease |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> AIDS | <input type="checkbox"/> HIV Positive |

Describe any current medical treatment including drugs taken, even though not listed above _____

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointment without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

SIGNATURE _____ DATE _____

(PARENT OR GUARDIAN, IF PATIENT IS A MINOR)

JAMES Y. KIM, D.M.D., P.C.

*Northlake Commons • 3754 La Vista Rd • Suite 300
Tucker, GA 30084
404-728-1171 (Phone)
Fax: 404-728-1487 (Fax)*

OUR PAYMENT POLICY

We are not a preferred provider for any insurance company. If you are under contract with any insurance company, you will be responsible for any deductions and/or co-payments on the day services are rendered.

As a courtesy, we will gladly file any claims with non-contracted insurance companies. However, since we are a non-contracted provider, patients are responsible for any difference between fees between insurance and our practice.

Remember, insurance is not a guarantee of payment. You are responsible for the balance of your account regardless of benefit coverage.

*Evaluations and re-evaluations are due IN FULL the day of service regardless of insurance coverage. We will issue a refund if your insurance plan pays for these services OR refunds may be applied towards future treatment.

If you are unable to keep a scheduled appointment, a 24 hour cancellation fee will be charged to your account. Charges will be based on the length and type of your appointment.

X _____ Date: _____

X _____ Date: _____

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Dental Practice Policy

Dear Patient:

Welcome to our dental practice! We want to thank you for the opportunity to assist you with your dental needs. Our goal is to provide you with excellent dental care in an efficient and professional manner. Nevertheless, like any business, we have office policies that we must follow so that we can operate in a manner that will benefit our relationship. Our office policy serves as an agreement between Dr. James Y Kim, D.M.D., P.C., and the patient/debtor signed below.

We must have a 24 hour notice if you are unable to keep your scheduled appointment. If you are more than 15 minutes late to your scheduled appointment time, we may have to reschedule. We will make every effort to confirm your scheduled appointment with you. However, it is your responsibility to keep up with your appointment time. **If you fail to give us a 24 hour notice that you will be unable to come to your appointment, it will result in a \$35.00 broken appointment charge and will be billed to your account.**

Initials _____

As a courtesy, we will be glad to file your primary insurance. All co-pays are due at the time treatment is performed. Please be advised that treatment is not dependent on payment by your insurance company. Any fees quoted are an estimate based on information from your insurance carrier, not a guarantee of payment. Insurance claims that are not paid within 45 days become the sole responsibility of the patient. We will be happy to provide you with a copy of the insurance claim that will be submitted to your insurance carrier. You will be responsible for filing any secondary insurance carriers you have.

Return checks, stop payments and credit card charge backs will incur a fee of \$35.00 or 7% of the face amount, whichever is greater, and an amount equal to the charges incurred by the bank.

We thank you for choosing our dental practice and we look forward to a long relationship with you and your family.

_____ Date: _____

Patient/Guardian Signature if under 18

Sleep - Medical Update Questionnaire

1. Do you snore?
2. Do you have high blood pressure?
3. Has anyone reported that you choke or gasp for air while sleeping?
4. What is your neck size? (inches)
5. Do you wake refreshed?
6. Are you excessively tired during the day?