



New Patient Information

Welcome to Complete Smile Dentistry! We are so glad you have chosen us to meet and exceed your dental expectations. Please take this time to complete our patient registration, including the insurance information if you have not already given it to one of our staff members.

Name

Last _____ First _____ MI _____

Nickname _____ Email _____

Male _____ Female _____ Married _____ Single _____ Child _____ Birthdate _____

Social Security# _____

Driver's License # _____

Address

Street _____ City _____ State _____ Zip _____

Home# _____ Work# _____ Cell# _____

Employer _____ Occupation _____

Address _____ How Long There? _____

Insurance Information

Subscriber # _____ Social Security# _____ DOB _____

Insurance Co. _____ Group# _____ Phone# _____

Subscriber Employer _____

MEDICAL HISTORY Do you have a personal physician? _____

Are you currently under a physician's care? _____

Physician's Name _____ Physician's Phone # _____

YOUR CURRENT PHYSICAL HEALTH IS:

GOOD _____ FAIR _____ POOR _____

Do you smoke or use tobacco in any form? Yes ___ No ___

Katherine K. Yi, D.D.S.

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Do you have any implant , valves, rod or pins? Yes ___No___

Are you taking any medication? Yes ___No___

Please List: _____

FOR WOMEN: Are you taking birth control pills? Yes___No___

Are you pregnant? Yes__ No__ Week#:_____ Are you nursing ? Yes __ No__

Have you ever had any of the following diseases or Medical problems? (please check all that apply)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcers | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Cancer/Chemo | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Congenital Heart Defect |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Fainting/Dizzy Spells | <input type="checkbox"/> Shingles | <input type="checkbox"/> Sickle Cell Trait/Disease |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Artificial Joints/Valves | <input type="checkbox"/> Herpes |

Please list any serious medical condition(s) that are not listed above: (if none, please write NONE)

Are you allergic to any of the following? (Please Check) (if none, please write NONE)

- | | | | | |
|-------------------------------------|---------------------------------------|---------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Metals | <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Jewelry | <input type="checkbox"/> Sulfra | <input type="checkbox"/> Latex | <input type="checkbox"/> Tetracycline |

Questions or concerns?

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DENTAL HISTORY

What is the primary reason for your visit today?

Are you currently in pain? Yes __ No __

Do you require antibiotics before dental treatment? Yes__ No__

YOUR CURRENT DENTAL HISTORY IS:

GOOD____ FAIR____ POOR____

When was the last time you had a complete dental evaluation? _____

Have you ever had a serious/difficult problem associated with any previous dental work? Yes__ No__

Do you floss regularly? Yes__ No__

Brush Daily? Yes__ No__

Have you ever been informed or treated for the following?

Bleeding Gums

Osseous Surgery

Mobility of Teeth

Bad Taste / Odor

Cold Sores / Ulcers

Deep Cleaning / Scaling

Wisdom Teeth Extract

TMI /TMD Join Pain

Gum/Periodontal Disease

Oral Cancer / Biopsy

Hot/Cold Sensitivity

Toothbrush Abrasion

Would you like fresher breath? Yes__ No__

Would you like whiter teeth? Yes__ No__

Are you happy with how your smile looks? Yes__ No__

If not, what would you change? _____

WORK AUTHORIZATION & FINANCIAL POLICY

The undersigned hereby authorizes the Doctor to take x-rays, study, models photographs or any other diagnostics aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies certain risks. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a Finance charge will be added to any overdue balance. I also assign all insurance benefits to the Doctor. We respect that your time is valuable, please respect ours also, therefore, if appointments are continuously cancelled or charged without a 48hr notice; we require a reservations fee for future appointments.

Patient's (Parent) Signature _____

Date _____

Dentist Initials _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you the Notice about our privacy practices, our legal duties, and your rights concerning your health information. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. PATIENTS RIGHTS: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. You may request a copy of our Notice at any time.

Do we have your permission to send your information pertaining to our services by email? Yes___ No___

Do we have your permission to remind you by telephone or email of any appointment at home or mobile number? Yes___ No___

Do we have your permission to discuss any health information related to you with your family member, friend, or other person? Yes___ No___

By my signature below, I acknowledge that I have received the Notice of Privacy Practices from the office Complete Smile.

Name

Signature

Date

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PATIENT AGREEMENT FORM

Thank you for choosing Complete Smile as your dental treatment provider. In order to facilitate your treatment here we ask that you read and sign this agreement. If you have any questions, please ask for clarification.

For the patients with dental insurance, we will gladly verify and process your dental insurance with the following agreement:

- Your dental insurance is an agreement between you and your insurance company
- All patient copayments and/or patient portions are only an estimate and never guarantee of payment.
- As part of your contract with your insurance company, you are responsible for all out-of-pocket fee / deductibles and copayments.
- Insurance payments not paid after 90 days will become your complete responsibility and must be paid in full.

Missed Appointment or Short Notice Cancellations/ Reschedules:

We understand that your plans/ schedules can change. When they do, please contact us at least **48 hours** in advance. A fee of **\$50** will be charged to cancelations/ reschedules with less than 48 hours or with no notice prior to your appointment. By my signature below, I acknowledge that I have reviewed the patient agreement form and agree to the terms and policies.

Name

Signature

Date

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