Andrew H Kim DDS

294 South Main Street ◦ Suite A ◦ Templeton CA 93465
T: 805◦434◦1234 ◦ DrAndrewHKim@Gmail.com

PATIENT REGISTRATION

DATE

PATIENT INFORMATION

PATIENT'S NAME Last_____ First_____ M I_____ PREFERRED NAME_____

ADDRESS: Street _____ Apt # _____

City_____ State_____ Zip _____

HOME NO_____ CELL NO_____ WORK NO_____

EMAIL_____@_____ SEX: M F STATUS: Minor Single Married Divorced Separated Widowed Partnership

BIRTHDATE:_____ AGE: _____ Soc. Sec. # _____ DRIVER LIC #_____

PREFERRED METHOD OF CONTACT:_____

EMPLOYER_____ OCCUPATION _____ YEARS EMPLOYED_____

Who May We Thank for Referring You to our Office? _____

Reason for this Visit _____

RESPONSIBLE PARTY INFORMATION

NAME Last_____ First_____ Middle Initial _____

RELATION TO PATIENT_____ SEX: M F STATUS: Single Married Divorced Widowed

SOCIAL SECURITY #_____ BIRTHDATE_____ DRIVER'S LICENSE # _____

MAILING ADDRESS Street_____ Apt # _____

City_____ State_____ Zip _____

HOW LONG AT THIS ADDRESS_____ HOME PHONE_____ CELL PHONE _____

WORK PHONE_____ EMAIL _____@_____

PREVIOUS ADDRESS (if less than 3 yrs.) Street_____ Apt #_____

City_____ State_____ Zip_____ How Long_____

EMPLOYER_____ OCCUPATION _____

NO. YEARS EMPLOYED_____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME_____ RELATIONSHIP_____

ADDRESS _____ CITY_____ STATE_____ ZIP_____

HOME PH._____ CELL PH. _____ WORK PH. _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co._____ PH #_____

Insurance Co. Address _____

Insured's Employer_____

Insured's Soc. Sec. #_____ Group #_____

Insured's Member ID #_____ Local # _____

OTHER DENTAL INSURANCE INFORMATION (Secondary Carrier)

Insured's Name _____

Insurance Co._____ PH # _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. #_____ Group # _____

Insured's Member ID #_____ Local # _____

I assure the information on this page and the dental/medical history forms are correct to the best of my knowledge. I authorize Andrew H Kim DDS PC to utilize the information provided in conjunction with information collected utilizing diagnostic tools, not limited to radiographs, photographs, and diagnostic instruments, to diagnose, treatment plan, administer medications and treat oral disease necessary for proper dental care.

I authorize Andrew H Kim DDS PC to release any information pertaining to but not limited to dental/medical history, the records of examination, diagnosis, and treatment rendered to my self or my dependents during the period of such dental care, to third party payers and/or health professionals. I authorize and request my insurance company to pay directly to Andrew H Kim DDS PC insurance benefits otherwise payable to me.

Andrew H Kim DDS PC reserves rights to refer or decline services at our discretion.

PATIENT/GUARDIAN SIGNATURE: _____ DATE:_____

Andrew H. Kim D.D.S

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○ Yes ○ No _____
Are you on a special diet? ○ Yes ○ No
Do you use tobacco? ○ Yes ○ No
Do you use controlled substances? ○ Yes ○ No

Women: Are you
Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problem ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
			Yellow Jaundice ○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Andrew H Kim DDS

294 South Main Street ◦ Suite A ◦ Templeton CA 93465
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Financial policy

Thank you for choosing Andrew H Kim DDS PC as your dental care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial and Appointment Policy, which you need to read, understand, and sign prior to any treatment. And all patients must complete our Patient Registration and Health History forms before seeing the doctor.

Payment

I agree to be responsible for payment of all services rendered on my behalf or my dependents. Payment in full is due at the time of service unless prior financial arrangements are made. We accept the following forms of payment:

- Cash, Personal checks, Master Card, Visa and Discover
- We also offer special payment arrangements for charges over $1000 through **CARECREDIT**. Please ask for information if you are interested in this option.

The adult accompanying a minor will be responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date or previous arrangements have been made with the financial coordinator.

I agree to pay interest (2% per month, 24% APR) on any accrued indebtedness beyond 30 days, together with such collection costs and reasonable attorney fees as may be required to effect collection of this obligation. Checks that are returned to our office from your financial institution are subject to a $40.00 returned check fee. This fee covers the processing fees that are charged to our office.

Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Our office is committed to helping patients maximize their benefits. Because insurance policies vary greatly, we can estimate your coverage in good faith but cannot guarantee it. I understand that dental insurance carriers may pay less than the actual bill for services. As a service to our patients, we will be happy to manage all claim submission and follow up on your behalf. In the event we do accept assignment of benefits and your insurance company has not paid, the balance will be transferred to your account should the third party fail to pay in 60 days from the date of service. I understand that I am financially responsible for all charges whether or not paid by insurance or third party payers.

All insurance co-pays and deductibles must be paid at the date of service.

Delta Dental policy is to reimburse the subscriber instead of the services provider. Due to this policy, full payment arrangements are expected at the date of service.

Appointment Policy

We understand that your time is valuable and we will make every effort to see our patients at their scheduled time. We also ask our patients to, as a courtesy to our staff and other patients, to respect and value our time. Should a situation arise and you are 15 minutes late for your scheduled appointment, we may need to reschedule for another time and date.

Because we reserve time exclusively for each patient, we ask that, if possible, you not change your appointment. If you can't keep your scheduled appointment, we require a minimum of 48 hours notification so we can make your reserved time available for other patients. Appointments that are cancelled with less than 48 hours notice are considered a Broken Appointment and may be subject to a cancellation fee of $75 or 10% of an estimated treatment for the time, whichever is greater.

Thank you for understanding our Financial and Appointment Policy. Your cooperation is greatly appreciated. Please let us know if you have any questions or concerns.

I, _____, have read the Financial and Appointment Policy and agree to abide by its terms. I also understand this policy may be amended from time to time by the practice.

_____ _____

Signature of Patient/Responsible Party Date

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PATIENT CONSENT TO TREATMENT

Patient Name:_____ Date:_____

CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were unseen during the examination, for example, root canal therapy following a routine restorative procedure. I understand that I will be informed of needed changes during treatment and I give my permission to Andrew H Kim DDS PC and staff to make any/all changes and additions necessary to provide optimum treatment.

Initials_____

DRUGS, MEDICATIONS, AND ANESTHESIA:

I understand that antibiotics, analgesics, and other medications may cause adverse reactions, some of which are, but not limited to, redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest and anaphylactic shock.

I understand that medications, drugs, and anesthetics may cause drowsiness and lack of coordination, which can be enhanced by the use of alcohol or other drugs. I have been advised not to consume alcohol, nor operate any vehicle or hazardous device while taking medications and/or drugs, or until fully recovered from their effects.

I understand that occasionally, upon injection of local anesthetics, I may experience irritation and swelling of immediate areas. I also understand that local anesthetic may cause prolonged anesthesia, partial anesthesia, and in rare cases, permanent anesthesia.

Initials_____

HYGIENE AND PERIODONTICS (TISSUE AND BONE LOSS):

I understand that the long-term success of treatment and maintaining healthy status of my oral condition depends on my efforts at proper oral hygiene (i.e., brushing and flossing) and maintaining regular continual care visits with the dentist and hygienist.

PERIODONTITIS– I understand that I have a serious dental condition which may cause gum irritation, infection of periodontium, gum and bone loss, which if untreated can lead to teeth loss and other complications. The various treatment plans have been explained to me, including root planning and scaling, gum surgery, gum and bone replacements, and extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. Occasionally, treated teeth may require extraction.

PERIODONTAL CLEANING/ SCALING

I understand that most common complications are, but not limited to, pain, bleeding, tissue (gum) laceration, sensitivity to temperature, swelling, ulceration, infection, tooth fracture, and breaking of fillings.

Adverse reaction to fluoride treatment may be nausea and/or vomiting.

Initials_____

FILLINGS:

I have been advised of needed fillings to replace tooth structure lost due to caries, defect in existing restoration and/or to trauma. I understand that with time, fillings will need to be replaced due to wear and tear of materials. In cases where very little tooth structure remains, or existing tooth structure fractures off, I may need to receive more extensive treatment (such as root canal therapy, post and build-up, and/or crown), which will necessitate a separate charge.

I understand that the most common complications are, but not limited to, pain, sensitivity to temperature, fracture of tooth, nerve damage, damage to adjacent teeth, occlusal (bite) discrepancies, TMJ complications, reactions to drugs and/or anesthesia.

Initials_____

CROWN, ONLAYS, INLAYS, BRIDGE AND VENEERS:

I understand this procedure may require significant reduction of natural and/or restored tooth structures. I understand that at times, during the preparation of a tooth, pulp exposure may occur, necessitating root canal therapy.

I understand that matching the color of artificial tooth exactly to the natural teeth is difficult and may not be achieved to my desire. I further understand that I may be wearing a temporary restoration/s that may come off and that I must ensure to keep it on until the permanent restoration is delivered. It is also my responsibility to return for permanent cementation within 20 days of the preparation date. Excessive delays may allow undesired tooth movement. I understand that this may necessitate a remake of the crown or bridge and an additional charge may recur.

I realize that the final opportunity to make changes to my restoration (including shape, size, fit and color) will be before cementation. I understand that once cemented, the color and/or shade cannot be changed.

I understand that like natural teeth, crowns and bridges need to be kept clean, with proper oral hygiene and periodic cleanings, otherwise decay may develop underneath and/or around the margins of the restoration, leading to further dental treatment and or tooth loss. I further understand that restorations are subject to natural stress and wear at point may break or crack, of which I'll be responsible for repairs and/or replacement.

Initials_____

NEEDLE STICK:

If someone is inadvertently stuck with a needle used on me, I consent to have blood drawn for analysis.

Initials_____

I understand that dentistry is not an exact science and therefore reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I agree to cooperate completely with the recommendations of the doctor while I am under his/her care, realizing that any lack of cooperation could result in less than optimum results.

I certify that I have had an opportunity to read and fully understand the terms and words within, and consent to the explanation and treatment referred to or made, I have been encouraged to ask questions, and have them answered to my satisfaction.

I hereby authorize Andrew H Kim DDS PC at this facility and dental auxiliaries to proceed with and perform the dental procedures and treatments as had been explained to me.

Signature_____Relationship_____Date_____

Patient or Legal Representative

Andrew H Kim DDS

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Patient's Acknowledgement and Consent to HIPAA of 1996

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice (e.g. reminder or confirmation via email or text)

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient or Representative Signature

I,_____, have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information. Or the protected health information of the patient I am representing, to carry out treatment, payment activities, and health care operations.

_____ _____

Signature of patient/guardian Date

Patient Acknowledgment of Receipt of Dental Materials Fact Sheet

I, _____, acknowledge I have received from Andrew H Kim DDS PC a copy of the Dental Materials Fact Sheet dated May 2004.

_____ _____

Patient Signature Date

The following document is the Dental Board of California's Dental Materials Fact Sheet. The Department of Consumer Affairs has no position with respect to the language of this Dental Material Fact Sheet; and its linkage to the DCA website does not constitute an endorsement of the content of this document

The Dental Board of California
Dental Materials Fact Sheet
Adopted by the Board on October 17, 2001

As required by Chapter 801, Statutes of 1992, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be a complete guide to dental materials science. The most frequently used materials in restorative dentistry are amalgam, composite resin, glass ionomer cement, resin- ionomer cement, porcelain (ceramic), porcelain (fused-to-metal), gold alloys (noble) and nickel or cobalt-chrome (base- metal) alloys. Each material has its own advantages and disadvantages, benefits and risks. These and other relevant factors are compared in the attached matrix titled "Comparisons of Restorative Dental Materials." A Glossary of Terms" is also attached to assist the reader in understanding the terms used.
The statements made are supported by relevant, credible dental research published mainly between 1993 - 2001. In some cases, where contemporary research is sparse, we have indicated our best perceptions based upon information that predates 1993.
The reader should be aware that the outcome of dental treatment or durability of a restoration is not solely a function of the material from which the restoration was made. The durability of any restoration is influenced by the dentist's technique when placing the restoration, the ancillary materials used in the procedure, and the patient's cooperation during the procedure. Following restoration of the teeth, the longevity of the restoration will be strongly influenced by the patient's compliance with dental hygiene and home care, their diet and chewing habits.