19th Avenue Dental

Dr. Yun M. Kang, DDS
10217 19th Ave SE Suite 203
Everett, WA 98208
Phone: 425-385-8130 Fax: 425-385-2658

*Email:*_____ *Today's Date:* _____

Referred By: _____

*Name:*_____ *Home Phone:* _____ *Cell Phone:* _____

Address: _____

SS: _____ *Date of Birth:* _____ *Gender:* _____

Employer: _____

Emergency Contact: _____ *Relationship:* _____

Preferred Pharmacy: _____ *Phone #:* _____

Marital Status(Please Circle) : *Married* *Single* *Divorced* *Separated* *Widowed*

Student? If yes please provide school info: _____

Dental Insurance Information

Primary Insurance:

Name of Insured:_____
Insured Soc. Sec. :_____
Employer: _____
Insurance Co. : _____
Member ID: _____ Group # : _____
Birthdate :_____ Relationship to Patient :_____

Secondary Insurance:

Name of Insured:_____
Insured Soc. Sec. :_____
Employer: _____
Insurance Co. : _____
Member ID: _____ Group # : _____
Birthdate :_____ Relationship to Patient :_____

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Although dental personnel primary treat the area in and around your mouth, your mouth is a part of your whole body. Health problems that you may have, or medications that you take could have in important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now:	*If yes (provider name):*_____
Have you ever been hospitalized or had a major operation?	*If yes:* _____
Have you ever had a serious neck or head injury?	*If yes:* _____
Do you take or have you taken Phen-Phen or Redux?	*If yes:* _____
Are you on a special diet?	*If yes:* _____
Do you use tobacco?	*If yes:* _____
Do you use controlled substances?	*If yes:* _____

Women: Are you… Pregnant/trying to get pregnant? Nursing? Taking oral contraceptives?

Please circle if you are allergic to the following:

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs

If other please explain: _____

Aids/HIV positive	O Yes Or O No	Cortisone Med	O Yes Or O No	Hemophilia	O Yes Or O No	Radiation treatment	O Yes Or O No
Alzheimer's Disease	O Yes Or O No	Diabetes	O Yes Or O No	Hep A	O Yes Or O No	Recent weight loss	O Yes Or O No
Anaphylaxis	O Yes Or O No	Drug Addiction	O Yes Or O No	Hep B or C	O Yes Or O No	Renal disease	O Yes Or O No
Anemia	O Yes Or O No	Easily Winded	O Yes Or O No	Herpes	O Yes Or O No	Rheumatic fever	O Yes Or O No
Arthritis/Gout	O Yes Or O No	Emphysema	O Yes Or O No	High Blood Pressure	O Yes Or O No	Rheumatism	O Yes Or O No
Artificial Heart Valve	O Yes Or O No	Epilepsy	O Yes Or O No	High cholesterol	O Yes Or O No	Scarlet Fever	O Yes Or O No
Artificial Joint	O Yes Or O No	Excessive thirst	O Yes Or O No	Hives/rash	O Yes Or O No	Shingles	O Yes Or O No
Asthma	O Yes Or O No	Excessive bleeding	O Yes Or O No	Hypoglycemia	O Yes Or O No	Sickle cell disease	O Yes Or O No
Blood Disease	O Yes Or O No	Fainting Spells	O Yes Or O No	Irregular heart beat	O Yes Or O No	Sinus trouble	O Yes Or O No
Blood Transfusion	O Yes Or O No	Frequent Cough	O Yes Or O No	Kidney problems	O Yes Or O No	Spina bifida	O Yes Or O No
Breathing problems	O Yes Or O No	Diarrhea	O Yes Or O No	Leukemia	O Yes Or O No	Intestinal disease	O Yes Or O No
Bruise Easily	O Yes Or O No	Genital herpes	O Yes Or O No	Liver disease	O Yes Or O No	Stroke	O Yes Or O No
Cancer	O Yes Or O No	Glaucoma	O Yes Or O No	Low blood pressure	O Yes Or O No	Swelling of limbs	O Yes Or O No
Chemotherapy	O Yes Or O No	Hay fever	O Yes Or O No	Lung disease	O Yes Or O No	Thyroid disease	O Yes Or O No
Chest Pains	O Yes Or O No	Heart attack	O Yes Or O No	Mitral valve prolapse	O Yes Or O No	Tonsillitis	O Yes Or O No
Cold Sores/Blisters	O Yes Or O No	Heart mumur	O Yes Or O No	Osteoporosis	O Yes Or O No	Tuberculosis	O Yes Or O No
Heart Disorder	O Yes Or O No	Heart pacemaker	O Yes Or O No	Pain in jaw	O Yes Or O No	Tumors	O Yes Or O No
Convulsions	O Yes Or O No	Heart trouble	O Yes Or O No	Psychiatric care	O Yes Or O No	Yellow Jaundice	O Yes Or O No

Have you had any serious illness not listed above?

Comments:

_____
_____
_____
_____
_____

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Dental History

*Why have you come to the dentist today?*_____

Do you currently have pain or swelling?.....†*Yes* †*No*

Do you desire complete dental care?.....†*Yes* †*No*

Are your teeth sensitive to heat, cold, or sweets?.....†*Yes* †*No*

Do you have difficulty chewing food?.....†*Yes* †*No*

Do you grind or clench your teeth?.....†*Yes* †*No*

Do you ever have pain in your jaw joint or muscles?.....†*Yes* †*No*

Do you have clicking or popping in your jaw joint?.....†*Yes* †*No*

Do your gums ever bleed?.....†*Yes* †*No*

Have you ever had periodontal disease?.....†*Yes* †*No*

Are you worried about receiving dental treatment?.....†*Yes* †*No*

Would you prefer using laughing gas (nitrous oxide)?.....†*Yes* †*No*

Do you gag easily?.....†*Yes* †*No*

Your current dental health is?.....†*Good* †*Fair* †*Poor*

*Previous/Present Dentist: Name*_____*City*_____

*Date of Last Visit:*_____*When was your last cleaning?*_____

Are you happy with the color of your teeth?.....†*Yes* †*No*

Are you happy with the way your smile looks?.....†*Yes* †*No*

*If not, what would you change?*_____

Have you ever noticed slow healing sores in or around your mouth?.....†*Yes* †*No*

Have you lost any teeth?.....†*Yes* †*No*

Is it important to you to retain your natural teeth?.....†*Yes* †*No*

*How many times a day do you brush?*_____

*How many times a day do you floss?*_____

*Is there anything else we should know?*_____

_____

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Office Policies

We look forward to providing you with complete and personal dental care. We would like to gather information about your goals and current dental health to diagnose your dental needs. Together we would like to review your dental information and develop a treatment plan that fits those needs. Out of respect for your time, our time and our many other patients, please review our policies listed below.

Cancellations and No Shows

As a courtesy to our office, please make any changes or cancellations **48 hours** prior to your scheduled appointment. A cancellation with less than 24 hours' notice or failure to show for an appointment may result in a charge to your account at a minimum of $125.00, and is at the Office's Discretion.

Timeliness

We value your time and don't want to keep you waiting. Occasionally, we are delayed by an unexpected procedure with another patient, but please be assured that the quality of your care and treatment will not suffer. If you arrive more than 15 minutes late your appointment may be rescheduled.

Emergencies

For patients of record, we do our best to respond promptly to your needs. However, out of respect to our previously scheduled patients, we appreciate your flexibility as we work you into the best opening in our schedule.

Financial Policy

If you do not have insurance, we require full payment for treatment at each visit. For those with insurance, we will estimate approximate out of pocket portion which is due at the time of treatment, once insurance has paid you may have a residual balance owing which is the patient's responsibility.

We accept cash, check, visa or MasterCard. For those requiring payment plans we work with a third party company called lending club that may be able to assist you. It's important to communicate finical problems as soon as possible.

I acknowledge that I have read and understand the policies stated above. I, the undersigned, hereby agree that in the event of default of any amount due, and if the account is placed in the hands of an agency or attorney for collection or legal action, to pay the costs including agency, attorney fees and court costs incurred.

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Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of 19th Avenue Dental. The statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

19th Avenue Dental reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If Privacy Practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

Any Member of my Immediate Family_____ ☐Yes_____ ☐No_____
Spouse Only_____ ☐Yes_____ ☐No_____
Other (Please Specify):_____ ☐Yes_____ ☐No_____

_____ _____
Name of Patient or Personal Representative Signature of Patient of Personal Representative

_____ _____
Date Description of Personal Representative's Authority

Office Use Only Below This Line

Record of Acknowledgement not obtained

Provided prior to treatment?_____ ☐Yes_____ ☐No_____
Date Provided:_____
Reason for Denial: ☐Needed more time to review statement of Privacy Practices_____
☐Wanted to consult with another person, before signing_____
☐Unable to sign_____
☐Reason not given_____
☐Other
(Explain):_____

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