DR. CHO KWON
FAMILY DENTISTRY

NEW PATIENT FORM

PERSONAL INFORMATION

First Name **Last Name** **Middle Initial**

Preferred Name **Birthdate** **Social Security**

E-mail **Gender Assigned at Birth** ☐ Male ☐ Female

Address **City**

Apt / Unit **State** **Zip**

Employer/School **Occupation**

Cell Phone **Home Phone** **Work Phone**

Who may we thank for referring you?

Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered for _____ years ☐ Minor

EMERGENCY CONTACT

Contact Name **Home Number**

Relationship **Mobile Number**

DENTAL INSURANCE

Subscriber **Subscriber DOB**

Relationship to Subscriber **Insurance Co.**

Member ID **Subscriber SS#**

Subs. Employer **Group Number**

DENTAL INSURANCE #2

Subscriber **Subscriber DOB**

Relationship to Subscriber **Insurance Co.**

Member ID **Subscriber SS#**

Subs. Employer **Group Number**

PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST

CHO RYON KWON, DDS, PC
1492 H Street, Arcata, CA 95521
Phone (707) 822-7234 - Fax (707) 709-1303
chokwondds@gmail.com

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HEALTH HISTORY

FIRST NAME _____ LAST NAME _____

DENTAL HISTORY

Reason for today's visit _____

Do you have Full Mouth x-rays less than 5 years old? _____

Do you have BiteWing x-rays less than 6 months old? _____

Former dentist _____ **City / State** _____

Date of last dental visit _____ **Are you in pain?** _____

How often do you brush? _____ **How often do you floss?** _____

	YES	NO		YES	NO		YES	NO
Bad breath	☐	☐	Jaw pain or tiredness	☐	☐	Fingernail biting	☐	☐
Bleeding Gums	☐	☐	Lip or cheek biting	☐	☐	Food collection	☐	☐
Blisters on lips or mouth	☐	☐	Loose teeth / broken fillings	☐	☐	Grinding teeth	☐	☐
Burning sensation	☐	☐	Mouth breathing	☐	☐	Gums swollen/tender	☐	☐
Chew on one side of the mouth	☐	☐	Mouth pain when brushing	☐	☐	Sensitivity to cold	☐	☐
Cigarette or cigar smoking	☐	☐	Orthodontic treatment	☐	☐	Sensitivity to heat	☐	☐
Clicking or popping jaw	☐	☐	Pain around ear	☐	☐	Sensitivity to sweets	☐	☐
Dry mouth	☐	☐	Periodontal treatment	☐	☐	Sensitivity when biting	☐	☐

MEDICAL HISTORY

Name of medical doctor _____ **City / State** _____

Pharmacy _____ **Phone** _____ **Address** _____

Are you allergic to any of the following?

	YES	NO		YES	NO
Local Anesthesic	☐	☐	Penicilin	☐	☐
Aspirin	☐	☐	Latex	☐	☐
Codeine	☐	☐	Sulfa	☐	☐
Ibuprofen	☐	☐	Iodine	☐	☐

Other allergies _____

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FIRST NAME _____ LAST NAME _____

PRE-EXISTING CONDITIONS

	YES	NO
AIDS/HIV	☐	☐
Anemia	☐	☐
Arthritis, Rheumatism	☐	☐
Artificial Heart Valves	☐	☐
Ashtma	☐	☐
Back Problems	☐	☐
Bleeding Abnormally	☐	☐
Blood Disease	☐	☐
Blood Thinners	☐	☐
Chemical Dependency	☐	☐
Chemotherapy	☐	☐
Circulatory Problems	☐	☐
Congenital Heart Lesions	☐	☐
Contact Lenses	☐	☐
Cortisone Treatments	☐	☐
Cough	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
Epilepsy	☐	☐
Dry Mouth	☐	☐
Fainting or dizziness	☐	☐
Glaucoma	☐	☐
Headaches	☐	☐
Heart Murmur	☐	☐
Heart Problems	☐	☐
Hepatitis	☐	☐
Herpes	☐	☐
High Blood Pressure	☐	☐
Jaundice	☐	☐
Jaw Pain	☐	☐
Kidney Disease	☐	☐
Liver Disease	☐	☐
Low Blood Pressure	☐	☐
Mitral Valve Prolapse	☐	☐
Nervous Problems	☐	☐
Psychiatric Care	☐	☐
Radiation Treatment	☐	☐
Respiratory Disease	☐	☐
Rheumatic Fever	☐	☐
Scarlet Fever	☐	☐
Shortness of Breath	☐	☐
Sinus Trouble	☐	☐
Skin Rash	☐	☐
Special Diet	☐	☐
Swollen Feet or Ankles	☐	☐
Swollen Neck Glands	☐	☐
Thyroid Problems	☐	☐
Tonsilitis	☐	☐
Tuberculosis	☐	☐
Tumor on Neck or Head	☐	☐
Ulcer	☐	☐
Venereal Disease	☐	☐
Weight Loss, unexplained	☐	☐

Women:

	YES	NO
Birth control pills?	☐	☐
Nursing?	☐	☐
Are you pregnant?	☐	☐

Due date _____

	YES	NO			
Autoimmune Disease	☐	☐	Type		
Cancer	☐	☐	Type		
Heart Attack	☐	☐	Date		
Joint Replacement	☐	☐	Type	Date	
Pace Maker	☐	☐	Date		
Stent	☐	☐	Date		
Stroke	☐	☐	Date		

Other medical conditions

List any medications you are currently taking and the correlating diagnosis

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FINANCIAL AGREEMENT

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

GENERAL: Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

MISSED APPOINTMENTS: Unless we receive notice of cancellation 48 working hours in advance, you will be charged a minimum of $45 per hour. Please help us service you better by keeping scheduled appointments.

INSURANCE: Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pretreatment estimate which we send to the insurance company at your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your policy provides. If you have any questions concerning the pretreatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENTS: FULL PAYMENT is due at the time of service. If insurance benefits apply, we will bill your insurance on your behalf for payment to you, unless other arrangements have been made. We accept credit cards, cash and checks.

UNPAID BALANCE OVER 30 DAYS OLD WILL BE SUBJECT TO MONTHLY INTEREST OF 1.5% (APR18%). IF PAYMENT IS DELINQUENT, THE PATIENT WILL BE RESPONSIBLE FOR PAYMENT OF COLLECTION FEES, ATTORNEY'S FEES, AND COURT COSTS ASSOCIATED WITH THE RECOVERY OF THE MONIES DUE ON THE ACCOUNT.

By signing this Financial Agreement, I understand and agree that you are authorized to check my credit and employment history. I have read, understand, and agree to the terms and conditions of this Financial Agreement.

_____ Print Name

_____ Signature

DATE:

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PRIVACY PRACTICES

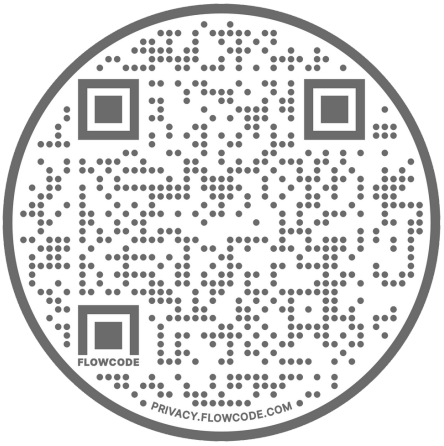
Notice of Privacy Practices

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

Dental Materials Fact Sheet

I acknowledge that I have had the full opportunity to read the contents of the Dental Materials Fact Sheet (updated May 14, 2017).

To read Notice of Privacy Practices and Dental Materials Fact Sheet, ask the receptionist for a copy or scan the QR Code below:



https://chokwondental.com/hipaa-notices

Print Name _____ Signature _____

DATE:

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