WELCOME

Patient Information

Date _____

SS/HIC/Patient ID # SSN# _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Birthdate _____ Age _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Phone (_____) _____ Work (_____) _____ Ext _____ Alt.Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Phone (_____) _____ Work Phone (_____) _____

Dental History

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

Health History

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No		
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No		
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No		
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No		
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No		
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No		
Back Problems	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No		
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No		
Blood Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No		
Cancer	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No		
Chemical Dependency	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No		
Chemotherapy	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No		
Circulatory Problems	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No		
Congenital Heart Lesions	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No		
Cortisone Treatments	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No		
Cough, persistent or bloody	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No		
Emphysema	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No				
		Radiation Treatment	☐ Yes ☐ No				

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name _____

Phone (_____) _____

Allergies

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Franklin Family
DENTAL CARE

9101 Franklin Square Drive, Suite 315
Medical Arts Building at Franklin Square Hospital
Baltimore, MD 21237
410-574-4616

www.franklinfamilydentalcare.com
www.franklinsquaredentistry.com

Additional Medical History:

For the following questions circle Yes or No. The answers are for our office records ONLY and is CONFIDENTIAL. A thorough and complete history is vital for a proper dental evaluation.

Yes No Congenital defects or hereditary problems?
Yes No Currently have or ever had a substance abuse problem?
Yes No Mental health or behavior problems?
Yes No Intellectual disability or on the Autistic Spectrum?
Yes No Vision, hearing, tasting or speech difficulties?
Yes No History of seizures ?

OTHER: _____

Notice of Privacy Practices for Protected Health Information (HIPPA):

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 (HIPPA). 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.

I have also been informed of, 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 right under HIPPA. I understand that you reserved 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 require to agree top 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 of disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: _____

Relationship to Patient (if minor): _____

Signature:_____ Date: _____

« **TURN OVER PAGE ----->>**

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Patient Consent For Treatment:

I request and authorize Dr. Kyle Yoon, and/or such other persons as he appoints, to perform or assist in the performance of needed dental treatment. I understand that this is for the purpose of, but not limited to, one of the following: diagnosis, pain, decay, periodontal disease for treatment, restorable, or non-restorable teeth, and any other conditions of the mouth. I further consent to any needed x-rays, medications, or referrals that might be necessary to correctly diagnose or treat my condition. I consent to, and authorize the performance of, any additional care, procedure, or treatment not specified about that the dentist believes necessary, as a result of unforeseen events or conditions. I understand that there have been no guarantees given or implied of any sort by anyone as to results that may be obtained. I consent to administration of any anesthetic deemed necessary and I understand that risks, including but not limited to; bruising, swelling, temporary or permanent numbness, sensitivity reaction, etc. I have given the opportunity to refuse to consent to any and all treatments proposed by not signing this document or rescinding this signature in writing. I understand that this is a general consent form and that I may be require to sign more specific consent forms based on the treatment that is proposed. I understand that my consent to dental treatment is also consent to dental charges for which I am fully responsible.

I certify that I have read and understood the above.

Signature of Patient/Guardian: _____Date: _____

Commitment of Understanding Our Office Policies to be Signed by All Patients:

1. Your appointment time is reserved exclusively for you. Any change in your appointment affects us all, thus a 24 hr notice to cancellation or rescheduling is required.

Less than a 24-hr notice is subject to a $35 charge to your account

For patients with MD Medical Assistance: You may not be charged for the broken appointments. However, ***there will be a loss of privileges to continue treatment at our office.***

2. **BROKEN APPOINTMENT POLICY:** If you have TWO or more broken appointments, we reserve the right to release you as a patient and ask that you seek treatment at another dental office.
3. **LATE ARRIVAL:** If you are over 15 minutes late for your appointment, we reserve the right to reschedule your appointment for a later time. The Broken Appointment Fee of $35 will apply as well. Please understand that we strive to stay on time for your appointment as well as those patients that follow you.
4. **RETURNED CHECKS:** will result in a $35.00 charge to your account.
5. **COLLECTIONS:** In the event that the account is not paid and we refer the account to a collection agency, you will be responsible for all fees incurred for the collection of your bill (i.e. attorney fees, court costs, and the collection agency fees)

I have read and understand the above information. I understand that I am responsible (regardless of my insurance) for any charges or fees incurred from services rendered.

Signature of Patient/Guardian: _____Date: _____

We create smiles that open doors for you!