



Dr. Nick Kim, DMD, MDS & Dr. Paul Kim

PATIENT REGISTRATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date
Patient's name (Last, First, Middle)
Address (Street, City, Zip)
Nickname, Birthdate, Age, Gender, School
Sports/Hobbies
Parent/Guardian name
Whom may we thank for referring you to our office?
Any friends, family members, or siblings we have treated? Name(s)?

RESPONSIBLE PARTY INFORMATION

Name (Last, First, Middle)
Residence (Street, City, Zip)
Mailing Address (Street, City, Zip)
How long at this address? Home phone, Work phone
Cell/other phone, Email address

How do you prefer to be contacted to remind you of future appointments?
Put a check in the box: Email?, Call?, Text?

Social Security #, Birthdate, Relationship to Patient
Employer, Occupation, No. years employed:
Spouse's Name, Relationship to Patient, Birthdate
Employer, Occupation, No. years employed:
Social Security #, Work Phone, Cell Phone

DENTAL INSURANCE INFORMATION

Policyholder Name, Policyholder SSN #, Birth Date
Insurance Company, Group No., Local No.
Insurance Co. Address, Phone No.
Do you have dual coverage? Yes, No, If yes:
Policyholder Name, Policyholder SSN #, Birth Date
Insurance Company, Group No., Local No.
Insurance Co. Address, Phone No.

EMERGENCY INFORMATION

Name of nearest relative not living with you
Complete address (Street, City, Zip)
Phone

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____
Please circle Yes or No (If Yes, please fill in details)

Yes No Is the patient taking any medication? _____
Yes No Is the patient allergic to anything? _____
Yes No History of a major illness? _____
Yes No Has the patient had any operations? _____
Yes No Ever been involved in a serious accident? _____
Yes No Have seen a physician in the last 12 months? Why? _____
Yes No Female Patients only: Is the patient pregnant? _____
Yes No Does the patient typically take antibiotics before dental cleanings? Why? _____

Circle any of the medical conditions below that the patient has had or currently has.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hay fever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

DENTAL HISTORY

General Dentist _____ Date of last visit _____
What concerns you most about your teeth? _____

Yes No Is the patient presently in any dental pain? _____
Yes No Ever experienced any unfavorable reaction to dentistry? _____
Yes No Has the patient ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Do gums bleed when brushing? _____
Yes No Any type of thumb or tongue habit? _____
Yes No Is the patient a mouth breather? _____
Yes No Has the patient ever seen an orthodontist? If yes, who and when? _____
Yes No What is the patient's attitude toward receiving orthodontic treatment? _____
Yes No Has anyone in the family received orthodontic treatment? _____
Yes No How did they feel about the result? _____
Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning? _____
Yes No Experience jaw clicking or popping? _____
Yes No Aware of clenching or grinding teeth during the day? _____
Yes No Experience "tension" headaches? _____
Yes No Has the patient ever experienced chronic ringing in the ears? _____
Yes No Does the patient need extra help with instructions? _____
Yes No Is the patient sensitive or self-conscious about his/her teeth? _____
Yes No Are you aware that some appointments will be during school hours? _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. I understand that, where appropriate, credit bureau reports may be obtained. In addition, I consent to a complete orthodontic evaluation.

Parent/Guardian _____ Date _____