

**Steve Kim, DDS**  
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[www.YourCarmichaelDentist.com](http://www.YourCarmichaelDentist.com)

**Welcome Patient Registration**

Patient Name (last, first, middle initial)		Date of Birth
Address		Social Security Number
City, State, Zip		Marital Status
Home Phone	Cell phone	Sex Male                      Female
Prefer ( ) morning appointments    or                      ( ) afternoon appointments		Relationship to Insured Self                      Spouse                      Child
Employer		Work phone
Occupation	E-mail Address	

**Who should be notified in case of an emergency?**

Name	phone
Address	relationship

**Insurance Information**

**Primary Coverage**

**Secondary coverage**

Subscriber's Name	Subscriber's Name
Date of Birth	Date of Birth
Insurance Company	Insurance Company
Social Security Number	Social Security number
Group number	Group number
Local number or policy number	Local number or policy number
Employer	Employer
Occupation	Occupation

**Verification of Benefits**

<b>For office use only</b>	Calendar year	<b>For office use only</b>	Calendar year
Yearly maximum\$	Deductible\$	Yearly Maximum\$	Deductible\$
FMX		FMX	
Prophv	Sealants	Prophv	Sealants
Electronic Pay Yes No	Pay or ID	Electronic Pay Yes No	Pay or ID

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**Health History**

Thank you for taking the time to fill out this important form accurately. At times, medication or procedures used in dentistry can affect other medical situations. Your responses are appreciated and are completely confidential.

**Please circle the appropriate answer:**

1. Would you consider yourself to be in good health? Yes No
2. Have you been hospitalized or had serious illness in the last three years? Yes No

If yes please explain \_\_\_\_\_

3. What was the date of your last medical exam/Doctor's Name? \_\_\_\_\_

4. Do you take medication (including aspirin)? Yes No

**Please list all medications and uses/dosage:**

5. Are you allergic to any medications or foods? Yes No

Please list allergies:

6. Do you require pre med before dental treatment (ex: artificial joint)? Yes No

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

<u>High Blood Pressure</u>	Yes	No
<u>Heart Murmur</u>	Yes	No
<u>Rheumatic Fever</u>	Yes	No
<u>Heart Defects</u>	Yes	No
<u>Chest Pain</u>	Yes	No
<u>HIV/AIDS</u>	Yes	No
<u>Headaches</u>	Yes	No
<u>Stroke</u>	Yes	No
<u>Sinus Problems</u>	Yes	No
<u>Asthma</u>	Yes	No
<u>Tuberculosis</u>	Yes	No
<u>Diabetes</u>	Yes	No
<u>Chemotherapy</u>	Yes	No
<u>Bleeding Problems</u>	Yes	No
<u>Kidney Disease</u>	Yes	No
<u>Psychiatric Care</u>	Yes	No
<u>Arthritis</u>	Yes	No
<u>Hepatitis</u>	Yes	No
<u>Latex Allergy</u>	Yes	No

<u>Cigarettes or Tobacco</u>	Yes	No
<u>Artificial Joint</u>	Yes	No
<u>Prosthetic Heart Valve</u>	Yes	No
<u>Heart Disease</u>	Yes	No
<u>Heart Attack</u>	Yes	No
<u>Seizures</u>	Yes	No
<u>Dry Mouth</u>	Yes	No
<u>Pacemaker</u>	Yes	No
<u>Seasonal Allergies</u>	Yes	No
<u>Lung Disease/COPD</u>	Yes	No
<u>Stomach Ulcers</u>	Yes	No
<u>Cancer</u>	Yes	No
<u>Radiation Treatment</u>	Yes	No
<u>Liver Disease</u>	Yes	No
<u>Thyroid Problems</u>	Yes	No
<u>Eye Disease/Glaucoma</u>	Yes	No
<u>Fainting Episodes</u>	Yes	No
<u>Drug Use or History Of</u>		
<u>Abuse</u>	Yes	No

**Women Only:**

Are you pregnant or nursing? Yes No Unsure

Are you taking birth control pills? Yes No

**Women taking birth control medications should be aware that antibiotics can cause the birth control medication to be ineffective possibly resulting in pregnancy.**

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**Dental History**

This form is used so that we can personalize your dental care and cater to your needs. This information is usually helpful and confidential.

1. What is the reason for today's visit? \_\_\_\_\_

2. When was your last dental appointment? \_\_\_\_\_

3. Previous Dentist Name? \_\_\_\_\_

4. Have you ever had problems with prior dental treatment?    Yes    No

5. Are you in pain now?            Yes    No

6. Do you have pain, clicking, or popping in your jaw joint (TMJ)?            Yes    No

7. How nervous are you about coming to the dentist? (Please circle one)  
Very Nervous            A Little Nervous            Not Nervous at All

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

9. Would you like to learn more about how you can improve your smile?            Yes    No

10. How did you hear about us? \_\_\_\_\_

### Financial Arrangements and Office Policy

**For all patients:**

**Payments, co-payments and deductibles are expected at the time service is provided.** If treatment requires multiple appointments, payment may be divided over the number of appointments. Cash, personal checks, Visa, Mastercard, American Express, and Discover are all accepted. If an extended payment plan is desired, please ask about our third party billing (finance) program or Electronic Funds Transfer (EFT). **Up to 15%** senior citizen discount is also offered. All unpaid accounts will be assessed a 1.5% monthly finance charge after 60 days. Delinquent accounts over 90 days could be referred to a collection agency. All fees incurred from the collection agency will be charged to the account.

**For patients with Dental Insurance:**

We accept almost all Dental PPO plans. As a complimentary service we will file your treatment plan with your insurance company. We will estimate your deductible and the portion not covered by your insurance. Our estimates may differ somewhat from your insurance company's calculations; therefore the amount due to our office may be adjusted accordingly. All procedures that are not covered by insurance are ultimately the patient's responsibility.

**Office Policy:**

If the need to cancel a scheduled appointment arises, we request 48 hours notification. Appointments cancelled within **48 hours** or "**No show**" appointments will result in a \$50 fee charged to your account. Two no-shows can result in a dismissal. Please turn off all cell phones prior to entering the treatment area. Again, interruptions of dentist and assistant can affect the quality of treatment.

**Patient Privacy:**

Our practice is committed to securing the privacy of your health information. This office follows guidelines set by the Department of Human and Health Services to protect the privacy of our patients' information.

**Our Promise:**

Thank you for choosing our office as your oral health care provider. We are a patient-centered dental office and provide comprehensive, modern dental care to our patients. We strive to maintain our standards through patient service, professionalism, compassion, efficiency, and continuing education. Every staff member takes pride in achieving high standards in dental excellence and values forming lasting relationships with our patients. We are honored to have you as our patient and will make every effort to exceed your expectations.

Steve Kim, DDS and Staff

Print Name \_\_\_\_\_

Signature and Date \_\_\_\_\_