



Patient Registration

❖ About You

Name: _____ Today's Date: _____
I like to be called: _____ Date of Birth: _____
Social Security #: _____ Driver's License #: _____
Marital Status: Single Married Divorced Widowed Other, Spouse's Name: _____
Employer: _____ Occupation: _____
Whom may we thank for referring you? _____
Special Interests or Hobbies: _____

❖ Contact Information

Home Address: _____ City, State, & Zip: _____
Home Phone: _____ Work Phone: _____
Email: _____ Cell Phone: _____
In case of an emergency, who may we contact on your behalf?
Name: _____ Phone: _____

❖ Responsible Party Information

(Please fill out if different from above)

Name: _____ Relation to Patient: _____
Social Security #: _____ Driver's Lic. #: _____
Home Phone: _____ Work Phone: _____
Home Address: _____ City, State, & Zip: _____

❖ Insurance Information

Primary Dental Insurance:

Name of Insured: _____ Relation to patient: _____
Insured's Birth Date: _____ Insured's SSN: _____
Insured's Employer: _____ Group/policy #: _____
Insurance Plan Name: _____ Insurance Phone #: _____
Insurance Address: _____

Additional Dental Insurance

Name of Insured: _____ Relation to patient: _____
Insured's Birth Date: _____ Insured's SSN: _____
Insured's Employer: _____ Group/policy #: _____
Insurance Plan Name: _____ Insurance Phone #: _____
Insurance Address: _____



Office Policy/Financial Responsibility Statement

1. I verify and understand that I am fully responsible for the fees and charges from my dental services provided by Dr. Dennis Baik.
2. Full payment or *estimated* co-payment of insurance is due at the time of the services.
3. It is my responsibility to inform the office of Dr. Dennis Baik if there is a change in my insurance status.
4. If after 90 days the insurance carrier had not paid a claim, it will then be my responsibility to pay the balance to Dennis Baik, DDS and collect from the insurance carrier directly.
5. I understand that as a **courtesy**, office of Dennis Baik, DDS will process my insurance claims. Nevertheless, I am fully aware that I am ultimately responsible for any portions not covered by my insurance
- 6 I will give at least 48 hours advance notice to the office of Dennis Baik, DDS for any cancellation or changes to my appointment.

Our office reserves the right to charge for appointments cancelled or broken without a full 48 hours advance notice.

7. ASSIGNMENT AND RELEASE OF INSURANCE BENEFIT

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly
Name of Insurance company(ies)

to Dr. Dennis Baik 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.

I authorize Dr. Baik to disclose my health care 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.

Name of Patient (Print): _____

Name of Responsible Party: _____ Relationship to Patient

Signature of Responsible Party: _____ Date: _____



Medical and Dental History

❖ Health Information

Name: _____ Age: _____ Male Female
 Name of Personal Physician: _____ Physician's Phone #: _____
 Date of Last Medical visit: _____ Current Health: Excellent Good Fair Poor

Please check 'yes' or "no" to indicate which of the following conditions you have had or currently have

	Yes	No		Yes	No		Yes	No
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Latex Allergy	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what? _____			Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Rhematism	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy (Seizure)	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valves	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>	Growths/Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problem	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Transplantation	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
(Unrepaired cyanotic)			High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Taken Fen-Phen ?	<input type="checkbox"/>	<input type="checkbox"/>
Currently Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Infective Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	Taken Bisphosphonates? <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, due date: _____			Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	(e.g. Fosamax, Actonel, or Didronel)		
Currently nursing?	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers/Stomach Prob.	<input type="checkbox"/>	<input type="checkbox"/>

• Do you have any medical conditions not listed above? Yes No

If yes, please explain: _____

• Are you taking any medications (including herbal)? Yes No

If yes, please list: _____

• Are you allergic to any medications? Yes No

If yes, please list: _____

• Have you been hospitalized within last two years? Yes No

If yes, please explain: _____

• Do you smoke or use chewing tobacco? Yes No, If yes, how much? _____

• Have you ever been diagnosed with **Obstructive Sleep Apnea**? Yes No

• Has anyone complained about your snoring? Yes No

• Do you often feel tired, fatigued, or sleepy during daytime? Yes No

• Has anyone observed you stop breathing during your sleep? Yes No

Patient Initial _____

❖ Dental History

Reason for today's visit: _____

Former Dentist: _____ City/state: _____

Date of last dental visit _____ Reason for the visit: _____

Indicate which of the following you have at present. Check "yes" or "no" to each item:

	Yes	No		Yes	No		Yes	No
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic treatment	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to cold	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	Fingernail biting	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to heat	<input type="checkbox"/>	<input type="checkbox"/>
Gums swollen or tender	<input type="checkbox"/>	<input type="checkbox"/>	Lip or cheek biting	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to sweets	<input type="checkbox"/>	<input type="checkbox"/>
Periodontal treatment	<input type="checkbox"/>	<input type="checkbox"/>	Mouth breathing	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity when biting	<input type="checkbox"/>	<input type="checkbox"/>
Clicking or popping jaw	<input type="checkbox"/>	<input type="checkbox"/>	Burning sensation on			Food collection		
Grinding teeth	<input type="checkbox"/>	<input type="checkbox"/>	Tongue	<input type="checkbox"/>	<input type="checkbox"/>	between the teeth	<input type="checkbox"/>	<input type="checkbox"/>
Jaw pain or tiredness	<input type="checkbox"/>	<input type="checkbox"/>	Sores or growths in			Loose teeth or broken		
Chew on one side of			your mouth	<input type="checkbox"/>	<input type="checkbox"/>	fillings	<input type="checkbox"/>	<input type="checkbox"/>
mouth	<input type="checkbox"/>	<input type="checkbox"/>	Blisters on lip or mouth	<input type="checkbox"/>	<input type="checkbox"/>	Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>

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

Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

Please RANK the following in the order of what would PREVENT YOU from receiving proper dental treatment

_____ FEAR _____ COST _____ LACK of concern _____ MISSING work time

❖ Smile Evaluation

Please check "yes" or "no" to each item in order to evaluate your smile:

	Yes	No		Yes	No
Are there any aspects of your smile that you are not happy about?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any spaces between your teeth that you don't like?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like to change the color of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Are any of your teeth chipped/cracked?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any concerns about the alignment/shape of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have fillings or dental work that you don't like looking at?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to any of above questions, please explain _____

The preceding information is correct to the best of my knowledge. I understand it will be held in the strictest of confidence and only be used to improve communication between Dr. Baik and myself. I also authorize Dr. Baik to contact my family physician and/ or my other medical specialist that I have listed above to obtain further medical information, if necessary.

Patient Signature: _____ **Today's Date:** _____

Dr. Signature: _____ **Today's Date:** _____

