Patient Information			
Name:	single married	Date of Birth:	
Parent or Guardian:			
Home Address: _____ _____ _____		Home Phone: _____ Cell Phone: _____ Work Phone: _____	
Email Address:		Preferred Contact: Cell Work Home Email	
Emergency Contact:	phone #:	Relation:	
Whom may we thank for referring you?			

Primary Dental Insurance		Secondary Dental Insurance	
Insurance Company:		Insurance Company	
Group Number:		Group Number:	
Employee:	Date of Birth:	Employee:	Date of Birth:
Date Employed:		Date Employed:	
Social Security or I.D. #		Social Security or I.D. #	

Medical Information				
Please circle any condition that pertains to you:				
Heart Disease/surgery	High Blood Pressure	Diabetes	Stroke	Premedication
Heart Murmur	Artificial Heart Valve	Liver Disease	Epilepsy	Cancer
Mitral Valve Prolapse	Breathing Problems	Kidney Disease	Fainting	Chemotherapy
Congenital Heart Disease	Sinus Problems	Arthritis	Tumors	Radiation Tx
Angina/Chest Pain	Bleeding Problems	Artificial joint	Psychiatric	Asthma
Heart Pacemaker	HIV / AIDS	Alzheimer's	Convulsions	Osteoporosis
Other Conditions that are unlisted:				
Medications: _____ _____ _____ _____ _____ _____ _____ _____			Drug Allergies: _____ _____ _____ _____	
Hospitalizations with dates:				
Physician's Name:		Physician Phone Number:		

Patient Signature: _____ *Date:* _____
Parent Signature: _____

Dental History	Dr. Notes
1. What is the primary reason for your appointment today? _____ 2. Are there specific areas of concern regarding your oral health? _____ 3. Have you had regular dental care? yes no 4. When was your last dental appointment? _____ 5. Name of Previous dentist: _____City: _____ 6. Have you ever seen a Periodontist or Orthodontist? yes no Name: _____City: _____ 7. When was your last complete series of x-rays (20 films)?_____ 8. Are you interested in saving your remaining teeth? yes no 9. How would you rate your smile (from 1 to 10) _____ 10. Do you have any esthetic concerns regarding your smile? yes no 11. If you could change your smile, what changes would you make? _____ 12. Do your teeth show signs of wear? yes no Does this concern you? yes no 13. Have you ever smoked or chewed tobacco? yes no 14. Do you have missing teeth? yes no Do these spaces concern you? yes no 15. Do you wear anything removable? yes no Denture Partial Denture Retainer Nightguard 16. Are you apprehensive about dental treatment? yes no 17. Have you ever had TMJ discomfort or joint/muscle pain? yes no 18. What are your main concerns regarding dentistry? _____ _____	

<u>Consent for Treatment and Notice of Privacy Practices</u>

1. *I authorize the office of Eugene Y. Rhee, D.D.S., P.A. to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate to make a thorough diagnosis.*
2. *The medical Information that I provided is accurate and complete. I agree to the use of local anesthetics if necessary and I understand that using any anesthetic embodies certain risks. I understand that I can ask for a complete explanation of the potential risks and complications.*
3. *I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.*
4. *I understand that 24 hours notice is required for All schedule changes and I understand that there is a charge for missed appointments if I do not provide adequate notice.*
5. *I acknowledge that I have read and if requested received a copy of the "Notice of Privacy Practice"*

Patient Signature: _____ *Date:* _____
Parent Signature: _____