MICHAEL J. MCKIM D.D.S

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Patient Information

Date:____/____/_____

❑Mr. ❑Mrs. ❑Ms. ❑Dr. First Name:_____ M.I.___ Last:_____

❑Male ❑Female Birth Date: ___/___/_____ Age:_____ Soc. Sec. #: _____

Street: _____ City: _____ State: ___ Zip: _____ Email: _____

Home Tel. : _____ Cell: _____ Best Time To Be Reached: _____

Previous Dentist: _____ Last Visit Date: _____ Referred To This Office By: _____

In Case Of Emergency, Please Contact: _____ Tel.: _____ Relation: _____

Driver's License Number: _____ Employer: _____ Job Title: _____

Family Members Seen By Us: _____

Who Will Be Responsible For Your Account?

❑Self ❑Spouse ❑Father ❑Mother ❑Other: _____

(If self, skip to next section)

Name: _____ S.S.#_____Birth Date: ___/___/_____

Street: _____ City: _____ State: ___ Zip: _____ Tel.: _____

Employer: _____ Position: _____ Bus. Tel.: _____

Spouse/Guarantor Information(if different from above)

Name: _____ Relation: _____ S.S.#: _____ Birth Date: ___/___/_____

Street: _____ City: _____ State: ___ Zip: _____ Tel.: _____

Employer: _____ Position: _____ Bus. Tel.: _____

Insurance Information

❑ Student ❑ Full-Time ❑ Part-Time ❑ Not School Name: _____

❑ Employed ❑ Full-Time ❑ Part-Time ❑ Retired ❑ Unemployed

❑ Married ❑ Divorced ❑ Separated ❑ Single ❑ Widow/er ❑ Other: _____

Primary Dental Insurance Company

Employer: _____

Bus. Address: _____

Bus. Tel.: _____ Plan: _____

Ins. Company Name: _____

Address: _____

_____ Tel.: _____

Group #: _____ Group Name: _____

Insured Party: _____

Relation: _____ Male Female

Birth Date: ___/___/_____ Tel.: _____

Street: _____

City: _____ State: _____ Zip: _____

Tel.: _____ S.S.#: _____

I.D. #: _____

Secondary Dental Insurance

Employer: _____

Bus. Address: _____

Bus. Tel.: _____ Plan: _____

Ins. Company Name: _____

Address: _____

_____ Tel.: _____

Group #: _____ Group Name: _____

Insured Party: _____

Relation: _____ Male Female

Birth Date: ___/___/_____ Tel.: _____

Street: _____

City: _____ State: ____ Zip: _____

Tel.: _____ S.S.#: _____

I.D.#_____

Dental Information

Reason For Today's Visit: _____ Last Dental Visit/X-Rays: _____

Are You In Pain? ❑ Yes ❑ No; If yes, for how long?_____ Sensitivity to: ❑ Hot ❑ Cold ❑ Sweets ❑ Biting

Please indicate any of the following problems by marking the corresponding box:

❑ Jaw clicking/popping	❑ Lost/broken fillings	❑ Gum disease	❑ Toothache	❑ Difficulty opening jaw	❑ Prolonged bleeding
❑ Red/swollen/bleeding gums	❑ Clenching/grinding	❑ Stained teeth	❑ Removable appliance	❑ Difficulty closing jaw	❑ Other: _____
❑ Oral blisters/sores	❑ Ringing in ears	❑ Locking jaw	❑ Burning tongue/lips	❑ Food catches in teeth	
❑ Recent infection/sore throat	❑ Broken/chipped tooth	❑ Bad breath	❑ Loose/shifting teeth	❑ Swelling/lumps in mouth	_____

Times a day you brush: _____ Times a week you floss: _____ How would you rate your smile?

Would you like whiter teeth? ❑ Yes ❑ No (worst) 1 2 3 4 5 6 7 8 9 10 (best)

Medical History

Are you in good health? ☐ Yes ☐ No Are you under a physician's care? ☐ Yes ☐ No Date of last visit: _____

Have you had any illness, operation, or been hospitalized in the past five years? ☐ Yes ☐ No

If so, please explain: _____

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N		Y	N	
☐	☐	Rheumatic fever	☐	☐	Asthma	☐	☐	Swollen ankles	☐	☐	History of drug abuse
☐	☐	Heart murmur	☐	☐	Hay fever/ Sinus problems	☐	☐	Malignant hyperthermia	☐	☐	Eye disease/ Glaucoma
☐	☐	Mitral valve prolapse	☐	☐	Snoring/ Sleep Apnea	☐	☐	Low blood sugar	☐	☐	Abnormal bleeding
☐	☐	High blood pressure	☐	☐	Problems w/immune system	☐	☐	Kidney trouble	☐	☐	Herpes/ Fever blisters
☐	☐	Low blood pressure	☐	☐	Bleeding tendency	☐	☐	Are you on dialysis?	☐	☐	Stomach ulcers
☐	☐	Chest pain/ Angina	☐	☐	Jaundice/ Liver disease	☐	☐	Arthritis/ Joint disease	☐	☐	Contagious diseases
☐	☐	Heart attack(s)	☐	☐	Hepatitis	☐	☐	Osteoporosis/ Osteopenia	☐	☐	Delay in healing
☐	☐	Irregular heart beat	☐	☐	Infectious mononucleosis	☐	☐	Osteonecrosis	☐	☐	Anemia
☐	☐	Cardiac pacemaker	☐	☐	Gallbladder trouble	☐	☐	Respiratory problems	☐	☐	Tumor or growth
☐	☐	Heart surgery	☐	☐	Fainting/ Dizzy spells	☐	☐	Tuberculosis	☐	☐	Radiation/ Chemotherapy
☐	☐	Bronchitis/ Chronic cough	☐	☐	Convulsions/ Epilepsy	☐	☐	Emphysema	☐	☐	Are you on a diet?
☐	☐	Chronic fatigue/ Night sweats	☐	☐	Stroke	☐	☐	Do you smoke?	☐	☐	Contact lenses
☐	☐	Difficulty climbing stairs	☐	☐	Thyroid trouble	☐	☐	Do you use chewing tobacco?	☐	☐	HIV/ AIDS
☐	☐	Mental health problems	☐	☐	Diabetes	☐	☐	Blood transfusion	☐	☐	Other:_____
☐	☐	Damaged heart valves	☐	☐	History of alcohol abuse	☐	☐	Blood disorder			
☐	☐	Are you immunosupressed?	☐	☐	Sexually transmitted diseases	☐	☐	Bruise easily			

Medication and Allergies

Are you taking now, or have you ever taken:

Y	N	
☐	☐	Nerve Pills
☐	☐	Diet Pills
☐	☐	Pain killers (including Aspirin)
☐	☐	Tranquilizers
☐	☐	Muscle relaxers
☐	☐	Stimulants
☐	☐	Antidepressants
☐	☐	Insulin
☐	☐	Blood thinners (Coumadin, Aspirin, Advil)
☐	☐	Any bone density medications(Aredia, Zometa,
☐	☐	Fosamax, Actonel)_____

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products)

_____

_____

Are you allergic to, or had a reaction to:

Y	N	
☐	☐	Penicillin
☐	☐	Valium/ other tranquilizers
☐	☐	Dairy products
☐	☐	Sulfa drugs/ Sulfites
☐	☐	Aspirin
☐	☐	Food dyes
☐	☐	Local Anesthetic
☐	☐	Codeine or other narcotics
☐	☐	Erythromycin
☐	☐	Tetracycline
☐	☐	Latex
☐	☐	Amoxicillin

Please list any other allergies: _____

_____

Women please answer the following:

(Women note: antibiotics (such as Penicillin) may alter the effectiveness of birth control pills. Consult your physician/ gynecologist for assistance regarding additional methods of birth control.)

Y	N	
☐	☐	Are you pregnant/ is there a possibility of pregnancy?
		Expected delivery date: _____
☐	☐	Are you nursing?
☐	☐	Are you taking birth control pills?

I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/ her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: *(Parent/Guardian if minor)* _____ Date: _____ Reviewed by: *(office use only)* _____ Date: _____

Fees and Payments

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure/ surgery you may require will be given to you upon request. If you have any dental and/ or medical insurance we will be glad to fill out the proper forms, but please complete identifying information on this form. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance company.** You will be responsible for all collection costs, attorney fees, and court costs.

Signature of patient: *(parent or guardian if minor)* _____ Date: _____

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient: *(parent or guardian if minor)* _____ Date: _____

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient: *(parent or guardian if minor)* _____ Date: _____