MARY W.M. KIM, DDS, MS
GERALD W.H. KIM, DDS, MSD

Patient's Name____________________ Birthdate____________________ Age________
Address____________________ Home Phone____________________
City______________ Zip________ Cell Phone____________________
School / Employer____________________ Work Phone____________________
Dentist____________________ E-mail____________________
Physician____________________ Insurance______________ SS#______________
Family / Friends being treated here______________________________
Referred by______________________________ (We would like to thank them for referring you to our office.)

Dad / Husband______________ Birthdate__________
Address____________________
Home Phone__________ Work Phone__________
Cell Phone__________ E-mail__________
Occupation____________________
Employer____________________
Insurance__________ SS#__________

Mom / Wife______________ Birthdate__________
Address____________________
Home Phone__________ Work Phone__________
Cell Phone__________ E-mail__________
Occupation____________________
Employer____________________
Insurance__________ SS#__________

Person responsible for this account______________ Relationship to patient______________
Address______________ □ Own □ Rent Years at address________ SS#__________
Employer______________ Years at current employer__________

Orthodontic concerns______________________________
Last dental visit / reason______________________________
Has all dental work been completed until the next regular check-up? □ Yes □ No
Have you been informed of any missing or extra teeth?____________________
Do your gums bleed? When?____________________
Do you have headaches? How often?____________________
Do you have jaw pain? Lock jaw? Clicking and popping of your jaw?____________________
Injury to mouth or jaw area?____________________
Car accidents?____________________
Do you have any dental disease, condition, or problem not listed above?____________________

Date of last medical exam / significant findings____________________
Have you ever been hospitalized? When? Why?____________________
Are you or have you ever taken any pills, drugs, or medications? When? Why?____________________
List any general allergies and allergies to medications____________________

Do you have or have you ever had any of the following?

□ Asthma / Hay Fever	□ Heart Failure	□ Yellow Jaundice	□ Tuberculosis(TB)
□ Arthritis	□ Heart Murmur	□ Lumps / Tumors	□ HIV / AIDS
□ Bleeding Disorders	□ High Blood Pressure	□ Radiation Treatments	□ Heart Disease / Heart Surgery
□ Diabetes	□ Rheumatic Fever	□ Hepatitis	□ Venereal Disease
□ Epilepsy / Seizures	□ Liver Disease	□ Thyroid Disorders	(Syphilis, Gonorrhea, Herpes)
□ NONE	□ Other__________		

Describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your orthodontic treatment____________________

Signature of Patient / Guardian____________________ Date__________

CONSENT FOR USE OF HEALTH INFORMATION

Prior to using or disclosing your protected health information to carry out treatment, payment, health care operations, or other approved activities, **Kim Orthodontics LLC / Gerald W.H. Kim, D.D.S., M.S.D. / Mary W.M. Kim, D.D.S., M.S.** is required under federal law to obtain your consent Please sign and date this consent below

By signing this consent, you agree that we may use or disclose your protected health information to carry out **treatment, payment, health care operations and other normal business activities** in our office

You have the right to request restrictions on how your protected health information is used or disclosed, however, we are not required to agree to such restrictions If we agree to a restriction that you request, such a restriction will be binding

You have the right to revoke this consent in writing, except to the extent that we have taken action in reliance on your consent

I, ______________________________, hereby certify that I have read the provisions set forth in this consent. I understand and agree to the terms of this consent. I understand that this consent is between **Kim Orthodontics LLC / Gerald W.H. Kim, D.D.S., M.S.D. / Mary W.M. Kim, D.D.S., M.S.** and me No other individuals/organizations have permission to obtain my confidential information under this consent This consent form will be kept in your patient file for a period of six (6) years.

______________________	X______________________	X______________________
Patient Name	Patient / Guardian Signature	Date Signed
______________________	______________________	
Office Representative	Date Received	

For Office Use Only

We attempted to obtain written consent for use of health information, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgment.
- ☐ An emergency situation prevented us from obtaining acknowledgment.
- ☐ Other (please specify).

______________________	______________________
Office Representative	Date