Today's Date ______________________

Jihun Moon, DDS, PLLC
General & Family Dentistry

Patient Registration and History

Welcome to our practice of dentistry. We appreciate your trust and confidence in our staff. Please take a few minutes to fill out this form. You may be assured that all information given will be kept confidential. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient

Name ______________________

Address ______________________

City ______________ State ______ Zip ______

Date of Birth ______________ ☐Male ☐Female

Social Security # ______________________

Phone Numbers: Home # ______________________

Cell # ____________ Work # ____________

E-Mail Address ______________________

Employer / School ______________________

Patient's Spouse / Parent (Please Circle)

Name ______________________

Address ______________________

City ______________ State ______ Zip ______

Date of Birth ______________ ☐Male ☐Female

Social Security # ______________________

Phone Numbers: Home # ______________________

Cell # ____________ Work # ____________

E-Mail Address ______________________

Employer / School ______________________

Notify in case of emergency ______________ Relationship to Patient ______________

Home Phone ____________ Cell Phone ____________ Work Phone ____________

Person Financially Responsible for Account ______________________

Primary Dental Insurance

Subscriber Name ______________ *Subscriber's* Social Security # ______________

Subscriber's Birthday ____________ Relationship to Patient ____________ Home Phone ____________ Cell # ____________

Address (*if different from patient)* ______________ City ____________ State ______ Zip ______

Subscriber Employed by ______________ Occupation ______________

Business Address ______________ Business Phone # ______________

Insurance Company ______________ Phone ______________

Group # ______________ Subscriber # ______________

Additional Dental Insurance

Subscriber Name ______________ *Subscriber's* Social Security # ______________

Subscriber's Birthday ____________ Relationship to Patient ____________ Home Phone ____________ Cell # ____________

Address (*if different from patient)* ______________ City ____________ State ______ Zip ______

Subscriber Employed by ______________ Occupation ______________

Business Address ______________ Business Phone # ______________

Insurance Company ______________ Phone ______________

Group # ______________ Subscriber # ______________

(over)

Dental History

What would you like us to do today?____________________________ Are you in dental discomfort today?_______________

Former Dentist___________________Address __________________Phone #____________ Date of last dental exam______

	Yes	No		Yes	No
1. Gums bleed while brushing	___	___	8. Frequent headaches	___	___
2. Teeth sensitive to hot/cold	___	___	9. Clench or grind your teeth	___	___
3. Teeth sensitive to sweet/sour	___	___	10. Bite lip or cheek frequently	___	___
4. Feel pain in your teeth/gums	___	___	11. Had any difficult extractions	___	___
5. Any sores in/near your mouth	___	___	12. Had any bleeding problem	___	___
6. Any pain in your jaw joint (TMJ)	___	___	13. Had orthodontic treatment	___	___
7. Had/have clicking in your (TMJ)	___	___	14. Do you wear dentures/partials	___	___
Limitation of opening mouth	___	___	If yes, date of placement:________________		

Patient Medical History

Medical Physician ___________________________________ Office Phone __________________ Date of last exam _________

Pharmacy ____________________________________ City _____________________________ Phone # __________________

	Yes	No		Yes	No
1. Are you under medical treatment now	___	___	4. Do you use any tobacco products	___	___
2. Use controlled substances	___	___	5. Hospitalized the past 5 yrs	___	___
3. List of current medications_______________________			If yes, please list _________________________		
____			6. Are you pregnant	___	___

Are you allergic to or have you had any reactions to the following: *(please circle)*

Local anesthetic(eg. Novocaine)
Sulfa Drugs
Sedatives
Other___________________________
Penicillin or any antibiotics
Barbiturates
Metals (nickel, mercury)
Aspirin
Latex rubber
Iodine
NONE ____________

Please circle any of the following which you have had or have at the present

AIDS/HIV
Anemia
Arthritis, Rheumatism
Artificial Heart Valves
Artificial Joints
Asthma
Back Problems
Bleeding abnormally with extractions or surgery
Blood Disease
Bruise Easily
Cancer ____________
Chemical Dependency
Chemotherapy
Circulatory Problems
Congenital Heart Lesions
Cortisone Treatments
Cough, persistent or bloody
Diabetes
Emphysema
Epilepsy
Fainting or dizziness
Glaucoma
Headaches
Heart Murmur
Heart Problems
Hepatitis Type ____
Herpes
High Blood Pressure
Jaundice
Jaw Pain
Kidney Disease
Liver Disease
Low Blood Pressure
Mitral Valve Prolapse
Nervous Problems
Pacemaker
Psychiatric Care
Radiation Treatment
Respiratory Disease
Rheumatic Fever
Scarlet Fever
Shortness of Breath
Sinus Trouble
Skin Rash
Special Diet
Stroke
Swollen Feet or Ankles
Swollen Neck Glands
Thyroid Problems
Tonsillitis
Tuberculosis
Tumor or growth on head or neck
Ulcer
Venereal Disease
Weight Loss, unexplained
Any Bone Drugs
Other _______________

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist or staff to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors. I understand that my dental insurance may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on behalf of me or my dependents.

Signature of patient *(or parent if minor):* ____ *Date:*____________

This form was reviewed for accuracy/completeness on: ________,________,________,________,________