Choon Sung Park, D.M.D.

Your Smile Says So Much! Why Are You Hiding It?

Date_____

5329 Office Center Court Suite 105 Bakersfield CA 93309 661-864-1364

Patient Information (confidential) *Patient Email*_____

Name _____**Birthdate**_____ **Soc Sec#**_____

Address_____**City**_____**Zip Code**_____**Home #**_____ **Cell#** _____

Work#_____ **Circle Appropriate Status Minor Single Married Divorced Widowed Separated**

If Student, Name of School or College_____ **City**_____**State** _____ **Zip Code**_____

If yes, is Student part time _____ **or full time**_____ **Do you have a copy of the student's class Schedule** ____ **yes** _____ **no**

Patient's or Parent's Employer_____ **Business Address**_____ **State**_____**Zip Code**_____

Spouse or parent's name _____ **Employer**_____ **Work Phone** _____ **Cell Phone**_____

Whom (OR WHAT) may we thank for referring you! _____ **Person to Contact in Case of Emergency** _____ **#**_____

Name of person completing this form _____ **Relationship to Patient**_____ **Signature**_____

Responsible Party-Note – The parent or guardian who brings child will be responsible for account regardless of custody

Name of person responsible for this account for the entire family_____ **Relationship to Pt.**_____

Address _____ **Home phone#**_____ **Cell phone #**_____

Driver License # (required)_____ **Birthdate**_____ **Financial Institute**_____

Employer_____ **Work Phone #**_____**SS #**_____

Insurance Information

Name of Insured_____ **Relationship to patient**_____ **Insured SS#**_____

Birthdate of Insured_____ **Name of Employer**_____ **Date Employed**_____

Address of Employer_____ **City**_____ **State**_____ **Zip code**_____

Insurance Company Name_____ **Insurance Co. Phone #**_____ **Group #**_____

Insured-subscriber ID#_____ **Insurance Address** _____ **City**_____ **State**_____

Does patient have secondary or other Insurance Yes_____ No_____ Please fill out if yes

Name of Insured_____ **Relationship to Patient** _____ **Insured SS#**_____

Birthdate of Insured_____ **Name of Employer** _____ **Date Employed**_____

Address of Employer _____ **City**_____ **State** _____ **Zip Code**_____ **Group #**_____

Insurance Company Name_____ **Insurance Co.Phone #**_____ **Address**_____

Patient Dental History

Name of previous dentist and location _____ **Date of last exam**_____

Circe Yes or No

Do your gums bleed?	**Yes**	**No**	**Do you bite your lips or cheeks frequently?**	**Yes**	**No**
Are your teeth sensitive to hot or cold?	**Yes**	**No**	**Have you had previous problems with dental treatment in the past?**	**Yes**	**No**
Are your teeth sensitive to sweet or sour liquids or food?	**Yes**	**No**	**Have you ever had prolonged bleeding after Extractions?**	**Yes**	**No**
Do you feel pain to any teeth now?	**Yes**	**No**	**Do you clench or grind your teeth?**	**Yes**	**No**
Do you have sores, lumps in your mouth?	**Yes**	**No**	**Have you had any specialty care, ie-braces? Oral surgery?**	**Yes**	**No**
Have you had any neck, head, jaw injury?	**Yes**	**No**	**Do you wear dentures or partials?**	**Yes**	**No**
Have you had clicking or popping when chewing?	**Yes**	**No**	**Have you ever been treated for periodontal/ gum disease?**	**Yes**	**No**
Are you fearful or apprehensive of dental work?	**Yes**	**No**	**When was your last full mouth x-rays taken?** _____		
Do you engage in any sports activities?	**Yes**	**No**	**Have you had any trauma to the mouth?**	**Yes**	**No**