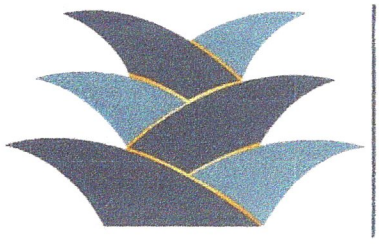

SAMMY B.D. PAK, D.D.S.
FAMILY DENTISTRY

Welcome to our office. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health.

Patient name_____ **Today's date**_____

Date of birth_____ **Age**_____ **Gender**_____

Social Security Number_____

Driver's license number_____ **State**_____

Home address

_____

_____

Phone_____ **Cell Phone**_____ **Email address**_____

Billing address *(if different from above)*

_____

_____

Employer/occupation_____

Spouse's name_____ **Spouse's phone**_____

Emergency contact and phone *(other than spouse)* _____

Primary dental insurance_____ **Group number**_____

Subscriber's name_____

Subscriber's insurance number_____ **Date of birth**_____

Secondary dental insurance_____ **Group number**_____

Subscriber's name_____

Subscriber's insurance number_____ **Date of birth**_____

Name of your medical doctor_____ **Last Visit** _____

Name of previous dentist_____ **Last Visit** _____

Referred to us by_____

MEDICAL HEALTH HISTORY:

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

	Yes	No
Heart Problems	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
Blood pressure problem	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Blood Problems	☐	☐
Easy bruising	☐	☐
Frequent nosebleeds	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Ever require a blood transfusion?	☐	☐
Allergy Problems	☐	☐
Hay fever	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Taking allergy medication	☐	☐
Asthma	☐	☐
Intestinal Problems	☐	☐
Ulcers	☐	☐
Weight gain or loss	☐	☐
Special diet	☐	☐
Constipation/Diarrhea	☐	☐
Kidney or bladder problems	☐	☐
Bone or Joint Problems	☐	☐
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement (e.g., total hip, pins, or implants)	☐	☐
Fainting Spells, Seizures, or Epilepsy	☐	☐
Stroke(s)	☐	☐
Frequent or severe headaches	☐	☐
Thyroid problems	☐	☐
Persistent cough or swollen glands	☐	☐
Premedications required by physician	☐	☐
Cancer/Tumor	☐	☐

Are you allergic, or have you reacted adversely, to any of the following?

	Yes	No
Local anesthetics ("Novocaine")	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐

Other _____

Notes: _____

_____

_____ Date: _____

	Yes	No
Diabetes	☐	☐
Urinate more than 6 times a day	☐	☐
Thirsty or mouth is dry much of the time	☐	☐
Family history of diabetes	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Do you drink alcohol?	☐	☐
If so, how much? _____		
Do you smoke?	☐	☐
If so, how much? _____		
Hepatitis, jaundice, or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV-positive/AIDS	☐	☐
Glaucoma	☐	☐
Do you wear contact lenses?	☐	☐
History of head injury?	☐	☐
Epilepsy or other neurological disease?	☐	☐
History of alcohol or drug abuse?	☐	☐

Do you have any disease, condition, or problem not listed previously that you feel we should know about?

If so, please describe: _____

During the past 12 months, have you taken any of the following?

	Yes	No
Antibiotics or sulfa drugs	☐	☐
Anticoagulants (e.g., Coumadin)	☐	☐
High blood pressure medicine	☐	☐
Tranquilizers	☐	☐
Insulin, Orinase, or similar drug	☐	☐
Aspirin	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐
Cortisone (steroids)	☐	☐
Natural remedies	☐	☐
Nonprescription drug/supplements	☐	☐

Other _____

_____

Women	Yes	No
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant?	☐	☐
If so, expected delivery date: _____		
Are you nursing?	☐	☐
Have you reached menopause?	☐	☐
If so, do you have any symptoms? _____		

_____

Notes: _____

_____

Patient/Parent Signature: _____

Dentist Initial: _____

Medication List:

Please list all medications you are currently taking

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Are you currently taking the medication **Eliquis (Apixaban)**? **Y or N**

If yes, how long have you been taking it? _____

Do you have **Osteoporosis**? **Y or N**

If yes, what medication are you taking for it and how long? _____

TMJ HEALTH QUESTIONNAIRE

PAIN SYMPTOMS

- ☐ Do you get "tension headaches" or "migraine headaches"?
- ☐ Do you feel you need treatment for this problem?
- ☐ Do you frequently have neck aches or stiff neck muscles?
- ☐ Do you have trouble sleeping soundly?
- ☐ Have your teeth been sore upon awaking?
- ☐ Does your jaw ache when you chew?
- ☐ Do you ever have ear pain?
- ☐ Do your jaws ache when you open wide?
- ☐ Have you ever had chronic shoulder or back pain?
- ☐ What medications, if any, are you taking for the pain? _____
- ☐ Do you grind your teeth when asleep?
- ☐ Are your jaws tired when you wake up?

Are your symptoms worse?

a. Upon rising in the morning
b. At work or school?
c. At home

How often do you take medicine for relief of pain?

a. Never
b. Weekly
c. Monthly
d. Daily

TRAUMA OR ACCIDENTS

- ☐ Have you ever had a severe blow to the head or jaw?
- ☐ Any whiplash neck injuries?
- ☐ Have you ever been involved in any serious accidents, such as a car accident?

JAW JOINT SYMPTOMS

- ☐ Does your jaw feel tired after a big meal?
- ☐ Do you ever get dizzy?
- ☐ Do you ever feel faint?
- ☐ Do you ever feel nauseated?
- ☐ Is there a family history of jaw joint (TMJ) problems?
- ☐ Do you feel or hear "clicking" or "popping" noise from either jaw?
- ☐ Has your jaw ever locked when you were unable to open or close?

EAR AND EYE SYMPTOMS

- ☐ Do you have itchiness or stiffness in either ear?
- ☐ Do you suffer from any loss of hearing?
- ☐ Do you get pain in, or around or behind either eye?
- ☐ Are there times when your eyesight blurs?
- ☐ Do you hear ringing, buzzing, or hissing sounds in either ear?

BREATHING

- ☐ Do you have allergies?
- ☐ Do you have sinus problems?
- ☐ Do you get headaches in right or left temple areas?

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

Sammy B.D. Pak, D.D.S., L.L.C.
409 2nd Street N.E., Puyallup, WA 98372
Phone 253-845-7611 Fax 253-845-0840

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

_____

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other

Financial Policy
for patients of
Sammy B.D. Pak, D.D.S.

Our policy is to establish financial arrangements prior to treatment, otherwise payment is due at the time of service. Estimates will be provided when requested. We accept checks, cash, Visa, and MasterCard.

We provide a 5% bookkeeping courtesy, if not billing your insurance, and payment is made at appointment time. Seniors over age 65, without dental insurance, will receive at least a 10% senior courtesy. Please let us know if you would like to take advantage of one of these options.

Dental Insurance, please circle: none single coverage dual coverage

If insured, do you want our office to file dental claims for services rendered?
Please circle: Yes No

If we are billing your insurance for you, please understand this is a courtesy. It would be to your advantage to research your dental benefits and understand the coverage as well as its limitations. If you have questions about your dental benefits, we may be able to help you get the answers. Frequently, dental plans do not cover all of the charges. We will help you receive maximum benefits, whenever possible. **Services are rendered to the patient and not the dental insurance company, hence the patient is ultimately responsible for charges regardless of estimates given by our office or your dental insurance company.**

Refunds will be subject to an 8% processing fee.

I understand the above financial policy and I am responsible for paying this account for services rendered:

_____ Date_____
(signature of responsible party)

Printed Name _____
(of responsible party)

Printed Name, if minor being treated_____

Office Policies

CANCELLATION POLICY:

In order to keep health care costs low for our patients, we must have a **48 hour** cancellation notice on any appointments. We do not accept cancellations over our voicemail. Please call the office during regular business hours to make any changes to your family's appointment. We understand that life gets in the way at times, but due to cancellation in the past we have found that this is the best way to keep our patients healthcare costs low. If there is more than one missed appointment without notice on your family account we will have to charge a **$75.00 fee**. We feel it is only fair to our patients and staff to take this action, and we hope that you understand our decision.

BILLING POLICY:

Your portion of your balance for services will be due at the time of service. We like to keep our patients wallets in mind as though you are our family. Paying at the time of service not only keeps costs low, but also allows you to know your current balance, and feel confident in the services you are receiving. There are payment plans available if needed, but we feel this policy is best for our practice as well as our beloved patients. If you have any questions about your account please feel free to call or visit our office.

Patient Signature: _____ Date: _____