ROBERT KIM, DDS
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avion DENTAL

Patient Information

Circle One: Dr/Mr/Mrs/Ms

First:_____ Middle:_____ Last:_____

Street:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ May we contact you by text? (circle) **Yes No**

Email Address:_____ May we contact you by email? (circle) **Yes No**

Social Security Number:_____ Date of Birth:_____ Sex: (circle) **M F**

Occupation:_____ Phone:_____

Emergency Contact:_____ Relationship to Patient:_____

How did you hear about Avion Dental?

☐ Yelp ☐ Google ☐ Magazine ☐ Referral ☐ Other:_____

Dental Insurance Information

Do you have Dental Insurance? (circle) **Yes No**

Do you have Secondary Dental Insurance? (circle) **Yes No**

Primary Insurance		Secondary Insurance	
Subscriber Name		Subscriber Name	
Subscriber Address		Subscriber Address	
Subscriber SSN		Subscriber SSN	
Date of Birth		Date of Birth	
Relationship	☐ Self ☐ Spouse ☐ Child ☐ Other	Relationship	☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name		Employer Name	
Insurance Name		Insurance Name	
Insurance ID		Insurance ID	
Insurance Group #		Insurance Group #	
Insurance Phone #		Insurance Phone #	

Medical Insurance Information

Do you have Medical Insurance? (circle) **Yes No**

Insurance Name		Insurance ID		Insurance Phone #	

****Please present Insurance Card(s) and photo ID to receptionist to be photocopied****

PAYMENT OPTIONS

At Avion Dental, we understand that affordability is an important consideration in dental treatment you may need and deserve. We offer a variety of payment options so your treatment is within reach. If you think you may be interested in one of our payment options, please inquire with our front staff and they will be happy to assist you.

Health Information

Patient Name:_____ Date of Birth:_____ Last Physical Exam:_____

Physician's Name and Phone #:_____

Reason for today's visit?_____

Work Related Injury? (circle) **Yes No** Have you been under the care of a physician? (circle) **Yes No**

Have you ever been hospitalized? (circle) **Yes No** If so, explain:_____

Have you visited another dentist in the past year? (circle) **Yes No** Dentist name:_____ Date of visit:_____

Date of last dental x-rays:_____ Have you ever had Novocaine or other local anesthetic? (circle) **Yes No**

Are you interested in tooth whitening? (circle) Yes No Are you interested in cosmetic dentistry? (circle) **Yes No**

Do you wear dentures/partials?:_____ Are you interested in dentures/partials? (circle) **Yes No**

Are you taking or have taken any steroid/cortisone therapy in the last 2 years? (circle) **Yes No**

Are you taking or have take any Oral Bisphosphonates, e.g., FOSAMAX, ACTONEL, BONIVA, or IV BISPHOSPHONATES, e.g., ZOMETA, AREDIA? (circle) **Yes No** Taken for how long?_____

Have you taken antibiotics prior to dental procedures in the past? (circle) **Yes No**

List any medications you are allergic to:_____

List any medications you are taking including non-prescription drugs, e.g. herbals, vitamins:_____

_____

Do you have a history of	Y	N		Y	N		Y	N		Y	N
Rheumatic fever			Asthma			Thyroid Disease			Alcoholism		
Heart Murmur			Allergies or Hives			Epilepsy or Seizures			Psychiatric Therapy		
Mitral valve prolapse			Anemia			Fainting or Dizziness			Mouth sore/growth		
Diabetes			Venereal Disease			Arthritis			Pain in jaw (TMJ)		
Pacemaker			Aspirin/Anticoag. Therapy			Ulcers or Stomach Problems			Teeth Grinding/Clenching		
Heart Surgery											
High Blood Pressure			HIV Positive/AIDS			Latex Allergy			Any type of Implant		
Low Blood Pressure			Blood Transfusion			Sinus Problems			Any transplant		
Heart Problem (_____)			Hepatitis (Type: _____)			Cancer (Type _____)			Joint Replacement		
Stroke			Excessive Bleeding			Chemotherapy			Other disease or illness:		
Lung Disease			Liver Disease			Radiation Treatment					
Breathing Problems			Kidney Disease			Use of Tobacco					
Tuberculosis (TB)			Dialysis			Drug Addiction					

Women	Y	N		Y	N
Is there a possibility of **pregnancy**?			Are you nursing?		
Estimated Due Date: / /			Are you taking any birth control prescriptions?		
NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your pharmacist/physician for assistance regarding additional methods of birth control.					

I certify I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge.

Patient (or Guardian) Signature:_____**Date:**_____