THE BRACE PLACE
& Kids Dentistry
AUDREY YOON, D.D.S., M.S.
562.804.1468 16424 Bellflower Blvd.
Bellflower, CA 90706

Patient Registration

❖ About You

Name: _____ Today's Date: _____
I like to be called: _____ Date of Birth: _____
Social Security #: _____ Driver's License #: _____
Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other, Spouse's Name:
_____
Employer: _____ Occupation: _____
Whom may we thank for referring you? _____
Special Interests or Hobbies: _____

❖ Contact Information

Home Address: _____ City, State, & Zip: _____
Home Phone: _____ Work Phone: _____
Email: _____ Cell Phone: _____
In case of an emergency, who may we contact on your behalf?
Name: _____ Phone: _____

❖ Responsible Party Information

(Please fill out if different from above)
Name: _____ Relation to Patient: _____
Social Security #: _____ Driver's Lic. #: _____
Home Phone: _____ Work Phone: _____
Home Address: _____ City, State, & Zip: _____

❖ Insurance Information

Primary Dental Insurance:
Name of Insured: _____ Relation to patient: _____
Insured's Birth Date: _____ Insured's SSN: _____
Insured's Employer: _____ Group/policy #: _____
Insurance Plan Name: _____ Insurance Phone #: _____
Insurance Address: _____
Additional Dental Insurance
Name of Insured: _____ Relation to patient: _____
Insured's Birth Date: _____ Insured's SSN: _____
Insured's Employer: _____ Group/policy #: _____
Insurance Plan Name: _____ Insurance Phone #: _____
Insurance Address: _____

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Office Policy/Financial Responsibility Statement

1. I verify and understand that I am fully responsible for the fees and charges from my dental services provided by Dr. Audrey Yoon

2. Full payment or ***estimated*** co-payment of insurance is due at the time of the services.

3. It is my responsibility to inform the office of Dr. Yoon if there is a change in my insurance status.

4. If after 90 days the insurance carrier had not paid a claim, it will then be my responsibility to pay the balance and collect from the insurance carrier directly.

5. I understand that as a courtesy, office of Dr. Yoon will process my insurance claims. Nevertheless, I am fully aware that I am ultimately responsible for any portions not covered by my insurance

6 I will give at least 48 hours advance notice to the office for any cancellation or changes to my appointment.

Our office reserves the right to charge for appointments cancelled or broken without a full 48 hours advance notice.

7. ASSIGNMENT AND RELEASE OF INSURANCE BENEFIT

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly
Name of Insurance company(ies)

to Dr. Yoon all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I authorize Dr. Yoon to disclose my health care information to the above-named insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Name of Patient (Print):_____

Name of Responsible Party: _____ _____
Relationship to Patient

Signature of Responsible Party:_____ Date:_____

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Medical and Dental History

❖ Health Information

Name:_____ Date of Birth: _____

Name of Personal Physician: _____ Physician's Phone #: _____

Date of Last Medical visit: _____ Current Health: ☐Excellent ☐Good ☐Fair ☐Poor

*Indicate which of the following you have had, or have at present. Check **"yes"** or **"no"** to each item.*

	Yes	No		Yes	No		Yes	No
AIDS/HIV	☐	☐	Diabetes	☐	☐	Liver Disease	☐	☐
Allergies	☐	☐	Dizziness/Fainting	☐	☐	Low Blood Pressure	☐	☐
If yes, what?_____			Emphysema	☐	☐	Mitral Valve Prolapse	☐	☐
Anemia	☐	☐	Excessive Bleeding	☐	☐	Nervous Disorder	☐	☐
Arthritis/Rhematism	☐	☐	Epilepsy	☐	☐	Pacemaker	☐	☐
Artificial Heart Valves	☐	☐	Glaucoma	☐	☐	Psychiatric Care	☐	☐
Artificial Joint	☐	☐	Growths/Tumor	☐	☐	Radiation treatment	☐	☐
Asthma	☐	☐	Heart Disease	☐	☐	Respiratory Problem	☐	☐
Blood Disease	☐	☐	Heart Murmur	☐	☐	Shortness of Breath	☐	☐
Cancer	☐	☐	Hepatitis Type_____	☐	☐	Sinus Problems	☐	☐
Chemical Dependency	☐	☐	Herpes	☐	☐	Stroke	☐	☐
Chemotherapy	☐	☐	High Blood Pressure	☐	☐	Tuberculosis	☐	☐
Currently Pregnant?	☐	☐	Jaundice	☐	☐	Taken Fen-Phen	☐	☐
If yes, due date:_____			Kidney Disease	☐	☐	Ulcers/Stomach Prob.	☐	☐
Currently nursing?	☐	☐	Latex Allergy	☐	☐			

Do you have any medical conditions not listed above? ☐Yes ☐No

If yes, please explain:_____

Are you taking any medications (including herbal)? ☐Yes ☐No

If yes, please list:_____

Are you allergic to any medications? ☐Yes ☐No

If yes, please list:_____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐Yes ☐No

If yes, please explain:_____

Are you under the care of a physician? ☐Yes ☐No

If yes, what for?_____

Do you smoke or use chewing tobacco? ☐Yes ☐ No If yes, how much per day?_____

Patient Initial _____

❖ Dental History

Reason for today's visit: _____

Former Dentist:_____ City/state:_____

Date of last dental visit_____ Reason for the visit:_____

*Indicate which of the following you have at present. Check **"yes"** or **"no"** to each item*:

	Yes	No		Yes	No		Yes	No
Bad breath	☐	☐	Orthodontic treatment	☐	☐	Sensitivity to cold	☐	☐
Bleeding gums	☐	☐	Fingernail biting	☐	☐	Sensitivity to heat	☐	☐
Gums swollen or tender	☐	☐	Lip or cheek biting	☐	☐	Sensitivity to sweets	☐	☐
Periodontal treatment	☐	☐	Mouth breathing	☐	☐	Sensitivity when biting	☐	☐
Clicking or popping jaw	☐	☐ ☐	Burning sensation on Tongue	☐	☐	Food collection between the teeth	☐	☐
Grinding teeth	☐	☐	Sores or growths in your mouth	☐	☐	Loose teeth or broken fillings	☐	☐
Jaw pain or tiredness	☐	☐	Blisters on lip or mouth	☐	☐	Dry mouth	☐	☐
Chew on one side of mouth	☐	☐						

How often do you floss?_____ How often do you brush?_____

Have you ever had any complications following dental treatment? ☐Yes ☐No

If yes, please explain:_____

Please RANK the following in the order of what would PREVENT YOU from receiving proper dental treatment

_____FEAR _____ COST _____LACK of concern _____ MISSING work time

❖ Smile Evaluation

*Please check "**yes**" or "**no**" to each item in order to evaluate your smile*:

	Yes	No		Yes	No
Are there any aspects of your smile that you are not happy about?	☐	☐	Do you have any spaces between your teeth that you don't like?	☐	☐
Would you like to change the color of your teeth?	☐	☐	Are any of your teeth chipped/cracked?	☐	☐
Do you have any concerns about the alignment/shape of your teeth?	☐	☐	Do you have fillings or dental work that you don't like looking at?	☐	☐

If you answered yes to any of above questions, please explain_____

_____

The preceding information is correct to the best of my knowledge. I understand it will be held in the strictest of confidence and only be used to improve communication between Dr.Yoon and myself. I also authorize Dr.Yoon to contact my family physician and/ or my other medical specialist that I have listed above to obtain further medical information, if necessary.

Name of Patient (print):_____

Signature:_____ **Today's Date:**_____

Dr. Signature:_____ **Today's Date:**_____