

ROSE E. KIM, DDS
AND
KATHLEEN L. MULCAHEY, DDS



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VALENCIA, CA 91355
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Patient Information

Name: _____ Sex: Male Female

Marital Status: _____ Date of Birth: _____

Address: _____

E-mail _____ Cell Phone: _____ Work Phone: _____

Employer _____ Occupation _____

Is there anything else you would like us to know about you? _____

How did you hear about our office? _____

Spouse/Additional Contact Information

Name: _____

Address (if different): _____

E-mail _____ Date of Birth: _____ Relationship to Patient: _____

Cell Phone: _____ Work Phone: _____ ext. _____

Employer _____ Occupation _____

Insurance Information

Primary Policy Holder Name: _____ Date of Birth: _____

SSN: _____ Subscriber/Member ID#: _____

Dental Insurance: _____ Group #: _____

If you have Dual Coverage

Secondary Policy Holder Name: _____ Date of Birth: _____

SSN: _____ Subscriber/Member ID#: _____

Dental Insurance: _____ Group #: _____

I authorize my insurance benefits to be paid directly to Valencia Smiles. In addition, I authorize Valencia Smiles to release any information required for all insurance claims. I accept full financial responsibility for all charges not covered by insurance benefits. I also understand that where appropriate, credit bureau reports may be obtained.

Signature

Date

Medical History

Physician _____ Phone: _____

Are you in good health? Yes No

Please list any medications you are currently taking: _____

Please list any allergies to medication: _____

Any allergies to: Plastic Metals Latex Dye Food: _____

Is there a medical condition requiring antibiotic coverage for dental treatment? Yes No

Have you ever had any of the following conditions (Please answer for each condition):

	YES	NO		YES	NO		YES	NO		YES	NO
Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Bone/Joint Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
ADHD/ADD	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/HIV+	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Feeding tube	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic/Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Cleft Lip/Palate	<input type="checkbox"/>	<input type="checkbox"/>	GERD	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia/Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinus, Ear, Adenoid/ Tonsil infections	<input type="checkbox"/>	<input type="checkbox"/>	Hearing/ Speech Impairments	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defects	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Visual impairments	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/ Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Special Needs	<input type="checkbox"/>	<input type="checkbox"/>
Birth Defects/ Genetic Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>			

Other/Please Specify: _____

Dental/Orthodontic History

General Dentist: _____ Last dental visit: _____

Have you ever had orthodontic treatment? Yes No

If yes, please describe: _____

What are your specific orthodontic concerns? _____

Have you ever had any of the following conditions (Please answer each condition):

	YES	NO		YES	NO		YES	NO		YES	NO
Injury to face, teeth, jaw	<input type="checkbox"/>	<input type="checkbox"/>	Clenching/grinding	<input type="checkbox"/>	<input type="checkbox"/>	Lip sucking/biting	<input type="checkbox"/>	<input type="checkbox"/>	Removal of Tonsils	<input type="checkbox"/>	<input type="checkbox"/>
Pain/discomfort in jaw joint	<input type="checkbox"/>	<input type="checkbox"/>	Mouth breathing/snoring	<input type="checkbox"/>	<input type="checkbox"/>	Pacifier habit	<input type="checkbox"/>	<input type="checkbox"/>	Missing or extra permanent teeth	<input type="checkbox"/>	<input type="checkbox"/>
Severe gag reflex	<input type="checkbox"/>	<input type="checkbox"/>	Nail biting	<input type="checkbox"/>	<input type="checkbox"/>	Thumb/ finger sucking	<input type="checkbox"/>	<input type="checkbox"/>	Cavities	<input type="checkbox"/>	<input type="checkbox"/>
			Tongue thrusting	<input type="checkbox"/>	<input type="checkbox"/>	Removal of Adenoids	<input type="checkbox"/>	<input type="checkbox"/>			

Consent for Treatment

I understand that the information that I have provided is correct to the best of my knowledge and that it will be held in the strictest of confidence. It is my responsibility to inform the office of any changes in my medical history.

The undersigned hereby authorize Dr. Rose Kim and Dr. Kathleen Mulcahey and/or associates and auxiliary personnel to perform dental care for me. This consent shall be active until cancelled by either party.

Signature

Date

Reviewed by

Date