Robert P. Choi, DDS
Rirchard P. Kinsel, DDS
Family & Cosmetic Dentistry

Welcome to our practice!

First Name | Middle Initial | Last Name

Responsible Party, if patient is a minor | Relationship to patient | Birthdate

Social Security No. | Email Address

Gender ☐ Male ☐ Female Marital Status ☐ Minor ☐ Single ☐ Married/Partnered ☐ Widowed ☐ Divorced/Separated

Street Address | City | State | Zip Code

Home Phone | Cell Phone

Business Phone | Ext | Employer | Occupation

Business Street Address | City | State | Zip Code

How did you hear about us?

☐ Referred By _____ Relationship

☐ Yelp ☐ Google ☐ Opencare ☐ Other _____

In case of an emergency, who should we contact?

Contact Name

Phone | Relationship

Insurance

Insured Member | Relationship to Patient

Employer | Telephone | Birthdate

Insurance Company | Group No. | Social Security No./ Subscriber ID No.

Secondary

Insured Member | Relationship to Patient

Employer | Telephone | Birthdate

Insurance Company | Group No. | Social Security No./ Subscriber ID No.

Dental History

Reason for today's visit

Former Dentist

City State

Date of last visit Date of last x-rays

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

- Y N Bleeding Gums
- Y N Burning Sensation on Tongue
- Y N Chewing on one side of Mouth
- Y N Fingernail Biting
- Y N Food Collection between Teeth
- Y N Frequent Headaches
- Y N Grinding Teeth
- Y N Gums Swollen or Tender
- Y N Jaw Difficulty, Clicking and/or Pain
- Y N Jaw, Head, or Neck Injuries
- Y N Loose Teeth or Broken Fillings
- Y N Orthodontic Treatment
- Y N Pain Around Ear
- Y N Periodontal Treatment
- Y N Sensitivity to Cold
- Y N Sensitivity to Heat
- Y N Sensitivity to Sweets
- Y N Sensitivity when Biting
- Y N Sores or Growths in Your Mouth
- Y N Tooth Pain

Medical History

Physician

Hospital Affiliation

City State Last Visit

- Y N Currently under medical treatment
- Y N Smoke, frequency: _____
- Y N Alcohol Use
- Y N Recreational drug use
- Y N Serious illnesses or operations:

Medications

Pharmacy Telephone

Allergies

- Y N Penicillin/Antibiotics
- Y N Sulfa Drugs
- Y N Barbiturates
- Y N Sedatives
- Y N Iodine
- Y N Latex
- Y N Metals
- Other

- Y N AIDS
- Y N Anemia
- Y N Arthritis, Rheumatism
- Y N Artifical Heart Valves
- Y N Artificial Joints
- Y N Asthma
- Y N Back Problems
- Y N Bleeding abnormally, with extractions or surgery
- Y N Blood Disease
- Y N Cancer
- Y N Chemical Dependency
- Y N Chemotherapy
- Y N Chronic Fatigue Syndrome
- Y N Circulatory Problems
- Y N Congenital Heart Lesions
- Y N Cortisone Treatments
- Y N Cough (persistent or bloody)
- Y N Diabetes
- Y N Emphysema
- Y N Epilepsy
- Y N Fainting or Dizziness
- Y N Glaucoma
- Y N Headaches
- Y N Heart Murmur
- Y N Heart Problems
- Y N Hepatitis, Type____
- Y N Herpes, Type____
- Y N High Blood Pressure
- Y N HIV Positive
- Y N Jaundice
- Y N Jaw Pain
- Y N Kidney Disease
- Y N Latex Sensitivity
- Y N Liver Disease
- Y N Low Blood Pressure
- Y N Mitral Valve Prolapse
- Y N Nervous Problems
- Y N Pacemaker
- Y N Psychiatric Care
- Y N Radiation Treatment
- Y N Respiratory Disease
- Y N Rheumatic Fever
- Y N Scarlet Fever
- Y N Shortness of Breath
- Y N Sinus Trouble
- Y N Skin Rash
- Y N Stroke, Date ____
- Y N Swelling of Feet/Ankles
- Y N Swollen Neck Glands
- Y N Thyroid Problems
- Y N Tonsillitis
- Y N Tuberculosis
- Y N Tumor or Growth on Head/ Neck
- Y N Ulcer
- Y N Venereal Disease
- Other

Women Only

- Y N Pregnant, Due Date: _____
- Y N Nursing
- Y N Using Birth-Control Pills

Office Use Only

Doctor Date

Assignment and Release

I hereby authorize payment directly to Robert P. Choi, DDS for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above practice and/ or any provider or supplier of services in this office to release this information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party Date