John H. Kim, DDS

19742 MacArthur Blvd. Suite 224, Irvine, CA 92612

Patient Intake Form

Personal Information

Last Name _____ First Name _____ Middle Name _____

Mailing Address _____ City _____ State _____ Zip Code _____

Date of Birth _____ Gender _____ Height _____ Weight _____ Social Security Number _____

Email Address _____ Marital Status _____ Occupation _____

Home Phone _____ Cell Phone _____ Work Phone _____

Please indicate your preferred number: □ Home Phone □ Cell Phone □ Work Phone

Emergency Contact Name _____ Relationship _____ Emergency Contact Phone _____

Reference Information

Referred by: □ Physician □ Dentist □ Family □ Friend □ Internet □ Other: _____

Name of Referring Physician _____ Specialty of Referring Physician _____

Address of Referring Physician _____ Phone Number of Referring Physician _____

We would like to update your healthcare providers (physicians, dentists, physical therapists, psychologists, etc.) on your diagnosis and treatment. Please provide their information to better facilitate your care. You may add additional healthcare providers on another sheet.

1. Provider:	**Specialty:**
Address:	Phone:
2. Provider:	**Specialty:**
Address:	Phone:
3. Provider:	**Specialty:**
Address:	Phone:

Insurance Information

Primary Insurance Plan Name _____ Group Number _____ Plan Number _____

Patient's Relation to Insured? □ Self □ Spouse □ Partner □ Child □ Other

If insured under someone else's insurance, please complete the following:

Insured's Full Name _____ Insured's Date of Birth _____

Mailing Address _____ City _____ State _____ Zip Code _____

Chief Complaint

What is the main reason for your office visit today?

_____

_____

Medication and Allergies

Please list any known allergies or bad reactions:

_____

_____

Please list any medications you are currently taking (including over-the-counter medication, vitamins, herbs) and its purpose:

_____

_____

_____

_____

Dental History

1. Date of Last Dental Exam: _____
2. Is future dental treatment needed? If yes, what? _____
3. Do you have painful or sensitive teeth? □ Yes □ No
4. Do your gums bleed easily or are any of your teeth loose? □ Yes □ No

Medical History

Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:

Current	Past	AIDS or HIV Infection	Current	Past	High Blood Pressure
Current	Past	Arthritis	Current	Past	Infectious Disease
Current	Past	Anemia/ Bleeding Disorder	Current	Past	Liver Disease
Current	Past	Autoimmune Disease	Current	Past	Low Testosterone
Current	Past	Back/Joint Problems	Current	Past	Mental Health, Depression, Anxiety
Current	Past	Bladder/Kidney Problems	Current	Past	Migraines
Current	Past	Cancer/Tumors	Current	Past	Neurological Disorder
Current	Past	Chronic Pain	Current	Past	Orthopedic (Surgery)
Current	Past	Epilepsy/Seizures	Current	Past	Sleep Apnea/Disorder
Current	Past	Erectile Dysfunction	Current	Past	Stroke
Current	Past	Gastrointestinal	Current	Past	Thyroid/Hormone Disorder
Current	Past	Headaches	Current	Past	Tonsils (Surgery)
Current	Past	Heart (Surgery)	Current	Past	Other: _____
Current	Past	Heart Disease	Current	Past	Other: _____

_____

_____

_____

_____

_____

Health History

1. Are you under a physician's care now? □ Yes □ No
   If Yes, why? _____
2. Have you been hospitalized recently? □ Yes □ No
   If Yes, why? _____
3. Do you have impending medical treatment? □ Yes □ No
   If Yes, what? _____
4. Do you have any physical or mental handicaps? □ Yes □ No
   If Yes, what? _____

5. Alcoholic Beverages: _____ drinks per week Tobacco Use: _____ packs per week

If you are a woman, please answer the following:

1. Are you pregnant? □ Yes □ No
2. Have you reached menopause? □ Yes □ No
3. Are you taking oral contraceptives? □ Yes □ No

Sleep History

1. Do you have trouble falling asleep?	□ Yes	□ No
2. Do you have trouble staying asleep?	□ Yes	□ No
3. Do people complain you snore?	□ Yes	□ No
4. Do you feel well rested in the morning?	□ Yes	□ No
5. Do you feel tired or doze while driving, working, reading, or watching TV?	□ Yes	□ No
6. Do you know if you stop breathing or has anyone witnessed you stop breathing?	□ Yes	□ No

TMJ/Facial Pain History

If you are in for TMJ or facial pain, please answer the following:

1. Are you aware of any of the following?

a. Grinding teeth	□ Yes	□ No
b. Clenching teeth	□ Yes	□ No
c. Jaw clicking/popping	□ Yes	□ No
d. Jaw grinding/grating	□ Yes	□ No

2. Does your jaw make noise?	□ Yes	□ No
3. Do you feel that your teeth fit together properly?	□ Yes	□ No
4. Have you had a traumatic accident or blow to the head?	□ Yes	□ No
5. Is your pain worse with stress or fatigue?	□ Yes	□ No

6. Do you have or have you had the following in the past?

a. Jaw Pain	□ Yes	□ No
b. Ear Pain	□ Yes	□ No
c. Headaches	□ Yes	□ No
d. Face Pain	□ Yes	□ No
e. Neck Pain	□ Yes	□ No
f. Sinus Problems	□ Yes	□ No

7. Have you ever had any of the following? □ Bite Adjustment □ Orthopedic Treatment □ Chiropractic
□ General Surgery □ Night Guard □ Physical Therapy

8. Have you ever had x-rays or imaging of your temporomandibular (jaw) joint? □ Yes □ No If Yes, how long ago? _____

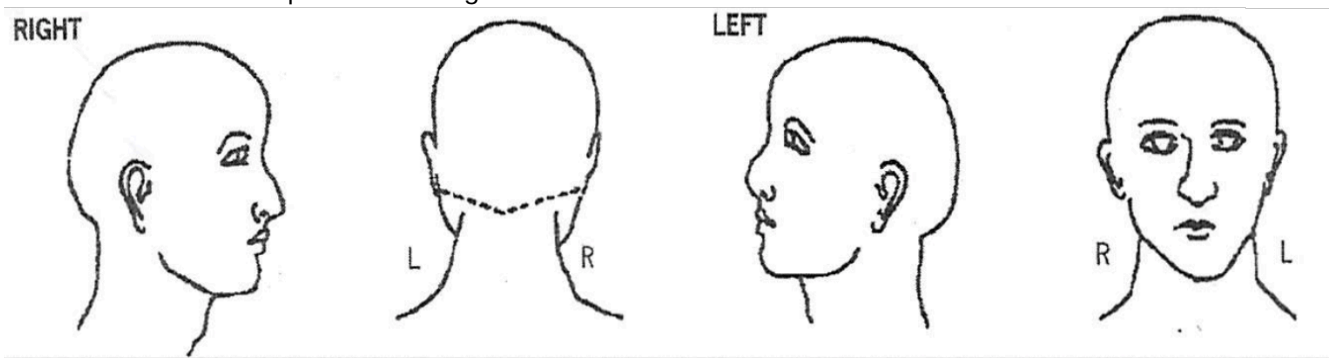
9. Please describe your pain: □ Aching □ Shooting □ Stabbing □ Electrical □ Throbbing □ Burning

10. Do you have any of the following with your pain?

a. Light Sensitivity	□ Yes	□ No
b. Nausea	□ Yes	□ No
c. Noise Sensitivity	□ Yes	□ No
d. Ringing Ears	□ Yes	□ No

11. On a scale of 1-10, 10 being the worst imaginable pain, how would you rate your pain right now? _____ at its worst? _____

Please outline the areas of pain on the diagram below:



I authorize the release of any medical/dental records to process this claim and the release of information regarding my treatment to healthcare providers listed on this form.

Signature: x_____ Relationship: _____

Authorization must be signed by the patient, or by the nearest relative in case of a minor or when the patient is physically or mentally incompetent.