IRVINE LAKE DENTAL
4660 Barranca Parkway
Irvine, CA 92604
949-857-2828

Patient Information

Name: _____ ☐ Male ☐ Female
Last First MI

Address: _____ City: _____ State: _____ ZIP: _____

SSN: _____ DOB: _____

Preferred Phone#: _____ Email: _____

Marital Status: ☐ Single ☐ Married

If you are a student: ☐ Full Time ☐ Part Time

Whom may we thank for referring you to Irvine Lake Dental? _____

Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured DOB: _____ Insured SSN: _____

Insured Address: _____ City: _____ State: _____ ZIP: _____

Email: _____

Insurance Name: _____ Insurance Group #: _____

Insurance ID#: _____

Employment Information

Insured Employer Name: _____ Occupation: _____

Authorization

I, the undersigned, certify that I (or my dependent) am covered by _____ insurance company and I assign directly to Lake Dental Group and David H Kim DDS Inc all insurance benefits, otherwise payable to me. I understand that I am responsible for the payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize Lake Dental Group and David H Kim DDS Inc to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electric.

Signature: _____ **Date:** _____

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Medical History

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

If yes, Physician's Name: _____ Date of Last Visit: _____

Physician's Phone: _____

Is your current physical health: ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription or over the counter medications? ☐ Yes ☐ No

If yes, please list: _____

Do you use tobacco in any form? ☐ Yes ☐ No

Have you ever taken Fosamax or any other bisphosphonates? ☐ Yes ☐ No

For women only: Are you pregnant? ☐ Yes ☐ No If yes, how many weeks? _____

Are you currently nursing? ☐ Yes ☐ No Taking birth control? ☐ Yes ☐ No

Do you have, or have had any of the following?

Y	N	Anemia	Y	N	Emphysema	Y	N	Mitral Valve Prolapse
Y	N	Artificial Joints/Valves	Y	N	Fever Blisters / Herpes	Y	N	Psychiatric Treatment
Y	N	Arthritis	Y	N	Heart Attack / Stroke	Y	N	Radiation Therapy
Y	N	Asthma	Y	N	Heart Murmur	Y	N	Rheumatic / Scarlet Fever
Y	N	Blood Transfusion	Y	N	Heart Surgery / Pacemaker	Y	N	Severe / Frequent Headaches
Y	N	Cancer/ Chemotherapy	Y	N	Hemophilia / Abnormal Bleeding	Y	N	Shingles
Y	N	Congenital Heart Defect	Y	N	Hepatitis	Y	N	Sickle Cell Disease
Y	N	Diabetes	Y	N	High/ Low Blood Pressure	Y	N	Sinus Problems
Y	N	Difficulty Breathing	Y	N	HIV / AIDS	Y	N	Tuberculosis (TB)
Y	N	Drug/Alcohol Abuse	Y	N	Hospitalization for any reason	Y	N	Ulcers / Colitis
Y	N	Epilepsy/Seizures /Fainting	Y	N	Kidney Problems	Y	N	Venereal Disease

Please list any medical condition(s) that is not listed: _____

Are you allergic to any of the following?

Y	N	Acrylics	Y	N	Codeine	Y	N	Latex
Y	N	Aspirin	Y	N	Erythromycin	Y	N	Penicillin
Y	N	Anesthetics	Y	N	Jewelry / Metals	Y	N	Tetracycline

Please list any other drugs or materials you are allergic to: _____

Dental History

Why are you visiting our office today? _____

Do you require antibiotics before treatment? ☐ Yes ☐ No

Are you in pain? ☐ Yes ☐ No

Have you ever had a serious or difficult problem associated with previous dental work? ☐ Yes ☐ No

Do you have pain or discomfort with your jaw joint? (TMJ/TMD) ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

How many times do you floss per week? _____ Brush per day? _____

When was your last dental visit? _____ Last dental cleaning? _____

Authorization

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services that I may need.

Signature: _____ **Date:** _____