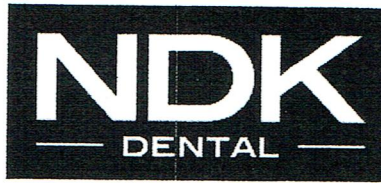


TELL US ABOUT YOURSELF



Name: _____ Male Female
Last First MI Title (Preferred Name)

Address: _____ City _____ State _____ ZIP _____

Marital Status: Single Married Widowed Divorced DOB: _____ SSN: _____

Home Phone: _____ Wireless Phone: _____ E-mail: _____

Employer: _____ Occupation: _____ Work Phone: _____

Preferred contact method: Home Phone Work Phone Wireless Phone E-mail

Preferred contact method for confirmations: Home Phone Work Phone Wireless Phone E-mail

Name of previous dentist: _____

How did you hear about our office? _____

Consent: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: _____

Do you have insurance? Yes No

(Complete the rest of this page only if you have insurance)

Insurance - Primary

Insurance Company Name: _____ Insurance Company Phone: _____

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber ID: _____ Group Name: _____ Group Number: _____

Insurance - Secondary

Insurance Company Name: _____ Insurance Company Phone: _____

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

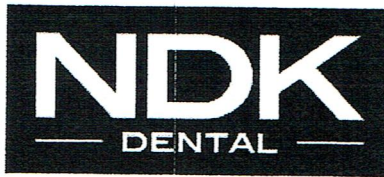
Subscriber ID: _____ Group Name: _____ Group Number: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to NDK Dental 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 hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship to Patient: _____ Date: _____



MEDICAL HISTORY

Do you have a personal physician? Yes No

If yes, Physician's Name: _____ Phone: _____ Date of last visit: _____

Your current physical health is: Good Fair Poor

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

If yes, please explain: _____

Do you use tobacco in any form? Yes No

Have you had any metal rods, pins or implants placed? Yes No

Are you taking any medications? Yes No

Please list each one: _____

Have you ever had any surgical procedures? Yes No

Please list each one: _____

- | Yes | No | Conditions |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol Abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina Pectoris |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Heart Valve |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusion |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Colitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Defect |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Breathing |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug Abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Facial Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting Spells |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever Blisters |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV + AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack |

- | Yes | No | Conditions |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis C |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse |
| <input type="checkbox"/> | <input type="checkbox"/> | Pace Maker |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Shingles |
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers |

- | Yes | No | Allergies |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin |
| <input type="checkbox"/> | <input type="checkbox"/> | Codeine |
| <input type="checkbox"/> | <input type="checkbox"/> | Dental Anesthetics |
| <input type="checkbox"/> | <input type="checkbox"/> | Erythromycin |
| <input type="checkbox"/> | <input type="checkbox"/> | Jewelry |
| <input type="checkbox"/> | <input type="checkbox"/> | Latex |
| <input type="checkbox"/> | <input type="checkbox"/> | Metals |
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin |
| <input type="checkbox"/> | <input type="checkbox"/> | Tetracycline |

- | Yes | No | If Female, Please Answer |
|--------------------------|--------------------------|----------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you taking Birth Control Pills? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant?
If so, # of Weeks _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you nursing? |

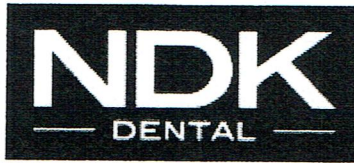
Nearest relative not living with you:

Name: _____ Relationship: _____

Address: _____ Phone: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____



Dr. Nicole DeVecco Kim
5835 Post Rd, Suite 113
E. Greenwich, RI 02818
(401) 884-3340

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of this
office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice Of Privacy Practices, but
acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

