Yong Chin Kim, DDS, MSD, Inc.

REGISTRATION

Last Name	First Name	❑ Male ❑ Female
Date of Birth	Home Phone #	Cell Phone #
Address	City & State	Zip Code
Patient's Employer	Occupation	Work Phone #
Emergency contact person	Relation to patient	Phone #
Family Dentist	Referred by (if not family dentist)	

Is this your first visit to our office? Yes_____No_____

CONFIDENTIAL HEALTH HISTORY

I. CHECK APPROPRIATE ANSWER (*If you are uncertain, please discuss it with the dentist*)

1. ❑ Yes ❑ No Is your general health good?

If NO, explain:_____

2. ❑ Yes ❑ No Are you being treated by a physician now, or have you been treated for a serious illness in the last two years? If YES, explain:_____

Date of last medical exam? _____Reason for exam:_____

Physician's Name: _____Phone Number:_____

3. List major surgeries or hospitalizations:_____

_____

4. List all PRESCRIPTIONS, OVER-THE-COUNTER MEDICATIONS, or SUPPLEMENTS being taken:_____

_____

5. Do you have any allergies to any drugs, medications or materials, such as novocaine, xylocaine, ibuprofen, aspirin, penicillin, codeine, latex, nickel, etc? (please list) _____

6. ❑ Yes ❑ No Are you taking Bisphosphonates?

II. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS? (Please check Yes or No for each)

❑ Yes ❑ No Congenital heart disease/artificial heart valve
❑ Yes ❑ No Heart attack
❑ Yes ❑ No Bacterial/infective endocarditis
❑ Yes ❑ No Stroke
❑ Yes ❑ No Fainting spells, seizure/epilepsy
❑ Yes ❑ No Cancer treatments
❑ Yes ❑ No Lung Disorders/Tuberculosis/Asthma/Emphysema, etc
❑ Yes ❑ No Blood disorders such as anemia
❑ Yes ❑ No Severe infection
❑ Yes ❑ No Immune disorder (Lupus, HIV, ARC, AIDS)
❑ Yes ❑ No Chest pain (angina) or shortness of breath
❑ Yes ❑ No Thyroid disease
❑ Yes ❑ No High/low blood pressure
❑ Yes ❑ No Artificial joint
❑ Yes ❑ No Diabetes
❑ Yes ❑ No Kidney or bladder disease
❑ Yes ❑ No Stomach or Intestinal problems
❑ Yes ❑ No Bleed or bruise easily
❑ Yes ❑ No Hepatitis, Jaundice, Liver Disease
❑ Yes ❑ No TMJ pain

❑ Yes ❑ No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain:_____

❑ Yes ❑ No Have you ever been pre-medicated for dental treatment? If YES, why:_____

❑ Yes ❑ No **Is there any issue or condition that you would like to discuss with the dentist in private?**

III. WOMEN ONLY (Please check Yes or No for each)

❑ Yes ❑ No Are you or could you be pregnant? If YES, what month?_____
❑ Yes ❑ No Are you nursing?
❑ Yes ❑ No Are you taking birth control pills?

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. If the dentist determines that there may be a potentially medically-compromised situation, I authorize the dentist to contact my physician for a medical consultation. I hereby consent to any necessary diagnostic procedures considered valuable by the dentist.

Signature of Patient (Parent or Guardian) **Date** **Signature of Dentist** **Date**

Yong Chin Kim, DDS, MSD, Inc.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Contact Officer: Yong Kim, D.D.S., M.S.D.
Telephone: (530) 673-1401; Fax: (530) 673-1466
E-mail: yubacityendo@gmail.com
Address: 1465 Live Oak Blvd, Yuba City, CA 95991

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Patient/Parent/Guardian Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF "FACTS ABOUT FILLINGS"

I have received a copy of the Dental Board of California's brochure, "The Facts About Fillings". When it is indicated, Dr. Kim may place an amalgam restoration. If you prefer another type of restoration, please indicate below.

_____ I do not wish to have amalgam restorations.

Patient/Parent/Guardian Signature Date

Endodontic Information and Consent Form

Endodontic (Root Canal) Treatment, Endodontic Surgery, Anesthetics, and Medications

We would like our patients to be informed about the various procedures involved in endodontic treatment and have their consent before starting treatment. Endodontic (root canal) treatment is performed in order to save a tooth which otherwise might need to be removed. This is accomplished by conservative root canal treatment, or, when needed, endodontic surgery. The following discusses possible risks that may occur from endodontic treatment and other treatment choices.

General Risks

Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections. These complications include: swelling; sensitivity; bleeding; pain; infection; numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, which is transient (temporary) but on infrequent occasions may be permanent; reactions to injections; changes to occlusion (biting); jaw muscle cramps and spasms; temporomandibular (jaw) joint difficulty; loosening of teeth; referred pain to ear, neck, and head; vomiting; allergic reactions; delayed healing; sinus perforations; and treatment failure.

Risks More Specific to Endodontic (Root Canal) Treatment

The risks include the possibility of instruments broken within the canals; perforations (extra openings) of the crown or root of the tooth; damage to bridges, existing fillings, crowns, or porcelain veneers; loss of tooth structure in gaining access to canals; and cracked teeth. During treatment complications may be discovered which make treatment impossible, or which may require dental surgery. These complications may include blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease), splits or fractures of teeth.

Medications

Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives, or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from their effects.

Alternative Treatments

These treatments include no treatment, waiting for more definite development of symptoms, and tooth extractions.
Risks involved in the choices might include pain, infection, swelling, loss of teeth, and infection of other areas.

Consent

I, the undersigned, being the patient (parent or guardian of minor patient) consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor. I also understand that upon completion of the root canal treatment in this office, I shall return to my general family dentist for a permanent restoration of the tooth involved, such as a crown, cap, jacket, onlay, or filling. I understand that root canal treatment is an attempt to save a tooth which may otherwise require extraction. Although root canal treatment has a high degree of success, it cannot be guaranteed. Occasionally, a tooth which has had root canal treatment may require retreatment, surgery, or even extraction.

Patient/Parent/Guardian Signature	Date
Patient/Parent/Guardian Name (Print)	Witness

CONE BEAM-COMPUTED TOMOGRAPHY (CBCT) IMAGING

A vital part of this practice is the ability to provide CBCT imaging. This technology is an advanced, state-of-the-art 3D imaging system that increases the quality and accuracy of dental care. The advantages of CBCT over conventional x-rays are:

- The most important advantage of CBCT is that it re-creates anatomic features in three dimensions that intraoral and panoramic images cannot.
- CBCT technology provides the dentist with an unparalleled visualization of the often complex relationships and boundaries between teeth and their associated pathology and anatomic features, such as the maxillary sinus and mandibular nerve.
- There is a greater chance for diagnosing conditions such as vertical root fractures that can be missed on conventional x-ray films.
- There is a greater chance of obtaining information which may aid in diagnosis, clarifying the cause of the problem and/or avoiding unnecessary dental treatment.
- It enhances your dentist's ability to see what needs to be done before treatment is started. Information such as the number of canals and severity of canal curvatures can be seen.

Understandably, you may have questions about radiation exposure. For comparison purposes, one day will expose you to 7-8 μSv of background radiation (radiation from the air, water, sun, etc). A CBCT exposes you to between 1 and 6 days worth of radiation (4.7 to 38.3 μSv). In contrast, a medical CT scan exposes you to 243 days worth of radiation (2000 μSv), while a medical cat scan exposes you to 1,515 days worth of radiation (10,000 μSv).

I certify that I have read the above statement. I understand the procedure to be used and its benefits, risks, and alternatives. I have been given the opportunity to have my questions answered.

PLEASE SIGN ONLY ONE:

I accept the risks of the CBCT scanning procedure as described above. I therefore give my consent to have Dr. Kim and his staff perform a CBCT scan.

_____ _____

Patient or Parent's/Guardian's Signature Date

---OR---

I **DO NOT** consent to have a CBCT scan.

_____ _____

Patient or Parent's/Guardian's Signature Date