KEVIN K.L. CHING, DDS

Name_____SS#_____

Address_____Zip Code_____

Home Phone_____ Mobile Phone_____ Email_____

Birthdate_____ Age_____ Single___ Married___ Other_____

Employed by _____ Occupation _____

Business Address _____ Bus Phone _____

Name of Spouse _____ Employed by _____

Name and Address of Nearest Relative (not living with patient) _____

_____

Dental Insurance Plan _____ Payment Plan: Cash / Credit Card / Monthly Carecredit

Referred By _____

1. Have you had a serious illness in the past? (Specify) _____
2. Are you under the care of a Physician? If so whom and what for? _____
3. Are you taking in any medications? No / Yes (specify) _____

_____

4. Do you have any allergies to any drug or medication? Yes / No
Aspirin Yes / No Novacaine Yes / No Lidocaine Yes / No Penicillin Yes / No Others Yes / No
Please explain: _____

5. If you have any of these health problems, please check appropriate spaces:
_High blood pressure _Lung Problems _Thyroid Problems _Rheumatic Fever or Rheumatic Heart Disease _Diabetes _Kidney Problems

_Heart Problems _Stroke _Jaundice _Hepatitis _T.B (Tuberculosis) _Venereal Disease, HIV, STD, AIDS _Ulcers _Allergies

_Unusual Bleeding _Bleeding gums _Thin Blood _Smoking _Cancer _Severe Dental Phobia

6. Any condition that will require special attention from us while you are in the office? (Specify)_____

_____

7. Are you pregnant? If so, what month? Yes / No ____ 8. Name of person completing the questionnaire: _____

9. Have you ever had a sore jaw join? Yes / No 10. What is the biggest problem with your teeth, gums, or mouth in general? _____

_____

_____

11. When was the last time you saw a dentist? What was done? _____

12. Are you happy with your teeth? _____ what changes would help improve your appearance? _____

_____

The above information is correct to the best of my knowledge.

_____ _____

Name Date

PATIENT INSURANCE VERIFICATION

PATIENT NAME: _____

DATE OF BIRTH: _____

HOME/CELL/WORK PHONE: _____

EMERGENCY CONTACT: _____

TELEPHONE NUMBER: _____

PRIMARY INSURANCE: _____

SUBSCRIBER NAME: _____

SUBSCRIBER SSN: _____

SUBSCRIBER DATE OF BIRTH: _____

INSURANCE TELEPHONE #: _____

INSURANCE MAILING ADDRESS : _____

_____

SECONDARY INSURANCE: _____

INSURANCE TELEPHONE#: _____

INSURANCE MAILING ADDRESS : _____

_____

SUBSCRIBER NAME: _____

SUBSCRIBER SSN: _____

SUBSCRIBER DATE OF BIRTH: _____

INSURANCE POLICY:

Our agreement for service is with you, our patient not with the insurance company, however, we do accept assignment of benefits as a courtesy.

We **do participate with all Delta Delta Insurances and Hawaii Dental Service**. We will accept "Assignmer of Benefits" with United Concordia, Metlife, Aetna, and any other private insurances. However, we **do not participate with HMSA** but we will help you maximize your insurance by filling all of your claims.

Regardless of what insurance you have does not guarantee of payment, so for any reason your insurance denie your claims, it is your responsibility to pay for those services in full.

_____ _____

SIGNATURE ***DATE***