

Welcome and thank you for choosing Yagasaki Dental Center! We provide advance family and cosmetic dentistry for every major dental need. To help us offer you the best experience on all your dental care need, please fill out the following questions completely. If you have any questions, please feel free to ask any of our staff and they will be happy to assist you.

DATE: I. PERSONAL INFORMATION BIRTHDATE: NAME: SOC. SEC. #:\_\_\_\_\_ ☐ MALE ☐ FEMALE MARITAL STATUS: ADDRESS: STREET CITY STATE ZIP CODE EMPLOYER:\_\_\_\_\_OCCUPATION:\_\_\_\_ REFERRED BY:\_\_\_\_\_ II. CONTACT INFORMATION HOME PHONE:\_\_\_\_\_ E-MAIL:\_\_\_\_\_ WORK PHONE:\_\_\_\_\_ PAGER:\_\_\_\_\_ EXTENSION #:\_\_\_\_ □ PAGER □ E-MAIL WHEN IS THE BEST TIME TO REACH YOU? TIME:\_\_\_\_\_ DAYS:\_\_\_\_\_ IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT?\_\_\_\_\_ HOME PHONE: \_\_\_\_\_ PAGER:\_\_\_\_\_ RELATIONSHIP TO PATIENT:\_\_\_\_\_ III. RESPOSIBLE PARTY RELATIONSHIP TO PATIENT:\_\_\_\_\_ BIRTHDATE:\_\_\_\_ DRIVER'S LICENSE #:\_\_\_\_\_ SOC. SEC.#: ADDRESS: STREET CITY STATE ZIP CODE EMPLOYER: OCCUPATION:

WORK PHONE: \_\_\_\_\_ EXT.:\_\_\_

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PRIMARY INSURANCE  SOC. SEC.#:  RELATIONSHIP TO PATIENT:  BIRTHDAY:  EMPLOYER:  DATE EMPLOYED:  OCCUPATION:  INSURANCE COMPANY:  INS. CO. ADDRESS:  STRET  GTY  STATE  ADDITIONAL INSURANCE  SOC. SEC.#:  BIRTHDAY:  INS. CO. ADDRESS:  STRET  AMOUNT ALREADY USED:  MAX. ANNUAL BENEFIT:  NAME OF INSURED:  SOC. SEC.#:  BIRTHDAY:  BIRTHDAY:  BIRTHDAY:  EMPLOYEE:  MAX. ANNUAL BENEFIT:  BIRTHDAY:  EMPLOYER:  DATE EMPLOYED:  OCCUPATION:  INSURANCE COMPANY:  INS. CO. ADDRESS:  STREET  GTY  STATE  BIRTHDAY:  INSURANCE COMPANY:  INS. CO. ADDRESS:  STREET  GTY  STATE  AMOUNT ALREADY USED:  MAX. ANNUAL BENEFIT:  V. PINANCIAL AGREEMINY  FOR YOUR CONVENIENCE, WE OFFER THE FOLLOWING METHODS OF PAYMENT.  PLEASE CHECK THE OPTION WHICH YOU PREFER.  CASH  PERSONAL CHECK  CREDIT CARD  JISCOVER  AMERICAN EXPRESS  IT I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services. In case of default on public to of this account, I agree to pay collection cost and reasonable attorney fees uncurred in attempting to collect on this amount or any future outstanding account balances.  I authorized the dentist to release any information including the diagnosis and the recods of any treatment or examination rendered to me during the period of such Dental care to third party papons and/or other health practitioners.  I authorized and request my insurance company to pay directly to the dentist of ental grapul insurance benefits on therwise payable to me I understand that my dental insurance carrier may pay less that the actual hill for services. I agree to be responsible for payment of services rendered on my behalf or my dependents	VI. DENTAL INSURANCE INF	FORMATION
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SIGNATURE OF PATIENT DATE	Y .	
	SIGNATURE OF PATIENT	DATE



## **HEALTH HISTORY**

NAME:		BIRTHDA	ATE:TODAY'S D	DATE:	
	DEN	ITAL HIS	STORY		
1. Reason of visit:					
2 111					
3. How often do you brush your teeth?					-
4. What texture brush do you use?	□ SOFT		1EDIUM  HARD		
	YES	NO		YES	NO
5. Do your gums bleed while brushing?			14. Do you have frequent headaches?		
6. Do your gums bleed while flosing?			15. Do you clench or grind your teeth		
7. Do you feel pain to any of your teeth when			while awake or asleep?	40.00	(e1-16)
brushing or flossing them?	_	_	16. Do you bite your lips or cheecks	П	П
8. Are your teeth sensitive to hot, cold, sweet	П		frequently?	_	
		_	3630003*30*30*30*03		
or sour foods/liquids?			17. Have you ever had:		
Have you noticed any loosening of your			a. Orthodontic treatment (braces)?		
teeth?	_	_	b. Oral Surgery?		
10. Does your food tend to become caught			c. Gum Treatment?		
between your teeth?	_		d. Your teeth ground or the bite		
11. Do you have any sores or lumps in or near			adjusted?		
your mouth?			e. Worn a bite plane or other		
12 Have you ever experienced any of the			appliance?		
following problems in your jaw?			18. Are you satisfied with the		
a. Clicking?			appearance of your teeth?		
b. Pain (joint, ear, side of face?)			19. Have you ever had an upsetting		
c. Difficulty opening or closing?			experience in the dental office?		
d. Difficulty in chewing?			20. Is there anything about having		
13. Have you everhad any head,			dental treatment that bothers you?		
neck or jaw injuries?					
	MED	ICAL HI	STORY		
Although dental personnel prima	arily treat the area in	and around	l your mouth, your mouth is a part of your bo	dy. Health	
			ld have an important interrelationship with the	ne dental care	
you a	40 P. M. S.		ering the following questions.	VEC	
	YES	NO		YES	NO
1. Are you in good health?		_	5. Are you now under the care of		
2. Have there been any changes in your		_	a physician?	_	_
general health in the past year?			6. Have you ever been hospitalized		
Date of last physical exam:     Physician's Name:			for any surgical operation or serious illness?		
Address:			Please explain:		
Phone #:					

	MEDICAL	L HISTO	RY (cont.)					
	YES	NO		YES	NO			
7. Are you taking Phen-fen medicine?			b. Are you ever short of breath					
Including non-prescription medicine?			after mild exercise?	12 <u></u> 2	<u>-</u> -			
If yes, what medicine(s) are you taking?			c. Do your ankles swell?					
8. Have you had any abnormal bleeding?			d. Do you get short of breath					
9. Do you bruise easily?			when you lay down?	_	_			
<ol><li>Have you ever required a blood transfusion</li></ol>			e. Do you require extra pillows					
11. Have you had a recent weight loss?			when you sleep?					
12. Do you use tobacco products?			6. Heart surgery?		님			
13. Do you use alcohol or cocaine or			7. High blood pressure?					
other drugs?			8. Low blood pressure?					
14. Are you wearing contact lenses?	D		<ol><li>Hepatitis, jaundice or liver disease?</li></ol>					
15. Do you have any disease, condition or			10. Stroke?					
problem not listed above that you think I		_	11. Sinus problems?		Ħ			
should know about?			12. Lung or breathing problems?					
FEMALES ONLY:			13. Asthma or hay fever?					
Are you pregnant or you think			14. Hives or skin rash?					
may be pregnant?	_	_	15. Fainting spells or seizure?					
2. Are you nursing			16. Diabetes?					
Are you taking birth control pills			17. AIDS or HIV infection?					
ARE YOU ALLERGIC TO OR HAD HAVE YOU	HAD A REACTION	TO:	18. Thyroid problems?					
Local anesthetic like NOVACAINE?			19. Allergies?					
2. Penicillin or other antibiotics?			20. Arthritis or rheumatism?					
3. Sulfa Drugs?			21. Joint replacement or implant?					
4. Barbiturates, sedatives or sleeping pills?			22. Stomach ulcer?					
5. Aspirin?			23. Kidney trouble?					
6. lodine?			24. Tuberculosis?					
7. Latex allergy?			25. Persistent cough?					
8. Other:			26. Cancer?					
DO YOU HAVE OR HAVE YOU EVER HAD	THE FOLLOWING		27. Sexually transmitted disease?					
<ol> <li>Rheumatic heart disease or rheumatic fever?</li> </ol>			28. Epilepsy?					
2. Scarlet fever?			29. Anemia?					
3. Heart defect ot heart murmur?			30. Leukemia?					
4. Heart trouble, heart attack, or angina?	□	□	31. Glaucoma?					
a. Do you have pain in your chest?								
			accurately answered. I understand that pro	5 (7) (1) (1)				
information can be dangerous to my h	ealth. It is my resp	onsibility t	o inform the dental office of any changes i	n medical status				
X								
SIGNATURE OF PATIENT			DATE					
FOR DENTIST ONLY								
SUMMARY OF DENTAL HISTORY:	TORE	ZEITII5	T OIVET					
SOMMANT OF BENTAETHSTONT.								
S								
SUMMARY OF MEDICAL HISTORY:								
-								
MEDICAL HISTORY UPDATE:				INTIALS				
DATE COMMENTS			PATIENT	T DENTIST	HYGIENIST			
-								