



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

NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_  
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 #: \_\_\_\_\_  
WHERE DO YOU PREFER TO BE REACH? ☐ HOME ☐ WORK ☐ 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: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ EXT.: \_\_\_\_\_

## VI. DENTAL INSURANCE INFORMATION

### PRIMARY INSURANCE

NAME OF INSURED: \_\_\_\_\_ SOC. SEC.#: \_\_\_\_\_  
RELATIONSHIP TO PATIENT: \_\_\_\_\_ BIRTHDAY: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_ DATE EMPLOYED: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
INSURANCE COMPANY: \_\_\_\_\_ GROUP #: \_\_\_\_\_  
INS. CO. ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIP CODE  
EMPLOYEE ID #: \_\_\_\_\_ DEDUCTIBLE: \_\_\_\_\_  
AMOUNT ALREADY USED: \_\_\_\_\_ MAX. ANNUAL BENEFIT: \_\_\_\_\_

### ADDITIONAL INSURANCE

NAME OF INSURED: \_\_\_\_\_ SOC. SEC.#: \_\_\_\_\_  
RELATIONSHIP TO PATIENT: \_\_\_\_\_ BIRTHDAY: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_ DATE EMPLOYED: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
INSURANCE COMPANY: \_\_\_\_\_ GROUP #: \_\_\_\_\_  
INS. CO. ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIP CODE  
EMPLOYEE ID #: \_\_\_\_\_ DEDUCTIBLE: \_\_\_\_\_  
AMOUNT ALREADY USED: \_\_\_\_\_ MAX. ANNUAL BENEFIT: \_\_\_\_\_

## V. FINANCIAL AGREEMENT

FOR YOUR CONVENIENCE, WE OFFER THE FOLLOWING METHODS OF PAYMENT.  
PLEASE CHECK THE OPTION WHICH YOU PREFER.

\_\_\_\_\_ CASH \_\_\_\_\_ PERSONAL CHECK \_\_\_\_\_ CREDIT CARD  
☐ VISA ☐ MASTERCARD  
☐ DISCOVER ☐ CARE CREDIT  
☐ AMERICAN EXPRESS

### LATE CHARGES

If 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 except for dental emergencies or where there is prepayment for additional services. In case of default on payment 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.

## V. FINANCIAL AGREEMENT

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 payors and/or other health practitioners.  
I authorized and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me  
I understand that my dental insurance carrier may pay less that the actual bill for services. I agree to be responsible for payment of services rendered on my behalf or my dependents

X \_\_\_\_\_  
SIGNATURE OF PATIENT DATE



## HEALTH HISTORY

NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

### DENTAL HISTORY

1. Reason of visit: _____					
2. When was your last dental visit? _____					
3. How often do you brush your teeth? _____					
4. What texture brush do you use?	<input type="checkbox"/> SOFT	<input type="checkbox"/> MEDIUM	<input type="checkbox"/> HARD		
	YES	NO		YES	NO
5. Do your gums bleed while brushing?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do your gums bleed while flossing?	<input type="checkbox"/>	<input type="checkbox"/>	15. Do you clench or grind your teeth	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you feel pain to any of your teeth when brushing or flossing them?	<input type="checkbox"/>	<input type="checkbox"/>	while awake or asleep?		
8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids?	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you noticed any loosening of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	17. Have you ever had:		
10. Does your food tend to become caught between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	a. Orthodontic treatment (braces)?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	b. Oral Surgery?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever experienced any of the following problems in your jaw?			c. Gum Treatment?	<input type="checkbox"/>	<input type="checkbox"/>
a. Clicking?	<input type="checkbox"/>	<input type="checkbox"/>	d. Your teeth ground or the bite adjusted?	<input type="checkbox"/>	<input type="checkbox"/>
b. Pain (joint, ear, side of face?)	<input type="checkbox"/>	<input type="checkbox"/>	e. Worn a bite plane or other appliance?	<input type="checkbox"/>	<input type="checkbox"/>
c. Difficulty opening or closing?	<input type="checkbox"/>	<input type="checkbox"/>	18. Are you satisfied with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
d. Difficulty in chewing?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have you ever had an upsetting experience in the dental office?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	20. Is there anything about having dental treatment that bothers you?	<input type="checkbox"/>	<input type="checkbox"/>

### MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your body. Health problems that may have, or medication that you may be taking, could have an important interrelationship with the dental care you are receiving. Thank you for answering the following questions.

	YES	NO		YES	NO
1. Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>	5. Are you now under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have there been any changes in your general health in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	6. Have you ever been hospitalized for any surgical operation or serious illness?	<input type="checkbox"/>	<input type="checkbox"/>
3. Date of last physical exam: _____			Please explain: _____		
4. Physician's Name: _____					
Address: _____					
Phone #: _____					



MEDICAL HISTORY (cont.)

	YES	NO		YES	NO
7. Are you taking Phen-fen medicine? Including non-prescription medicine? If yes, what medicine(s) are you taking? _____	<input type="checkbox"/>	<input type="checkbox"/>	b. Are you ever short of breath after mild exercise?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you had any abnormal bleeding?	<input type="checkbox"/>	<input type="checkbox"/>	c. Do your ankles swell?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>	d. Do you get short of breath when you lay down?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever required a blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	e. Do you require extra pillows when you sleep?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you had a recent weight loss?	<input type="checkbox"/>	<input type="checkbox"/>	6. Heart surgery?	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you use tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>	7. High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you use alcohol or cocaine or other drugs?	<input type="checkbox"/>	<input type="checkbox"/>	8. Low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
14. Are you wearing contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	9. Hepatitis, jaundice or liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you have any disease, condition or problem not listed above that you think I should know about?	<input type="checkbox"/>	<input type="checkbox"/>	10. Stroke?	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>FEMALES ONLY:</u></b>			11. Sinus problems?	<input type="checkbox"/>	<input type="checkbox"/>
1. Are you pregnant or you think may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	12. Lung or breathing problems?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you nursing	<input type="checkbox"/>	<input type="checkbox"/>	13. Asthma or hay fever?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking birth control pills	<input type="checkbox"/>	<input type="checkbox"/>	14. Hives or skin rash?	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>ARE YOU ALLERGIC TO OR HAD HAVE YOU HAD A REACTION TO:</u></b>			15. Fainting spells or seizure?	<input type="checkbox"/>	<input type="checkbox"/>
1. Local anesthetic like NOVACAINE?	<input type="checkbox"/>	<input type="checkbox"/>	16. Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
2. Penicillin or other antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>	17. AIDS or HIV infection?	<input type="checkbox"/>	<input type="checkbox"/>
3. Sulfa Drugs?	<input type="checkbox"/>	<input type="checkbox"/>	18. Thyroid problems?	<input type="checkbox"/>	<input type="checkbox"/>
4. Barbiturates, sedatives or sleeping pills?	<input type="checkbox"/>	<input type="checkbox"/>	19. Allergies?	<input type="checkbox"/>	<input type="checkbox"/>
5. Aspirin?	<input type="checkbox"/>	<input type="checkbox"/>	20. Arthritis or rheumatism?	<input type="checkbox"/>	<input type="checkbox"/>
6. Iodine?	<input type="checkbox"/>	<input type="checkbox"/>	21. Joint replacement or implant?	<input type="checkbox"/>	<input type="checkbox"/>
7. Latex allergy?	<input type="checkbox"/>	<input type="checkbox"/>	22. Stomach ulcer?	<input type="checkbox"/>	<input type="checkbox"/>
8. Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	23. Kidney trouble?	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:</u></b>			24. Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
1. Rheumatic heart disease or rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>	25. Persistent cough?	<input type="checkbox"/>	<input type="checkbox"/>
2. Scarlet fever?	<input type="checkbox"/>	<input type="checkbox"/>	26. Cancer?	<input type="checkbox"/>	<input type="checkbox"/>
3. Heart defect ot heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	27. Sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>
4. Heart trouble, heart attack, or angina?	<input type="checkbox"/>	<input type="checkbox"/>	28. Epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
a. Do you have pain in your chest?	<input type="checkbox"/>	<input type="checkbox"/>	29. Anemia?	<input type="checkbox"/>	<input type="checkbox"/>
			30. Leukemia?	<input type="checkbox"/>	<input type="checkbox"/>
			31. Glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>

To the best of my knowlwde, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status

X\_\_\_\_\_

SIGNATURE OF PATIENT

DATE

FOR DENTIST ONLY

SUMMARY OF DENTAL HISTORY:\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SUMMARY OF MEDICAL HISTORY:\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

MEDICAL HISTORY UPDATE:		INITIALS		
DATE	COMMENTS	PATIENT	DENTIST	HYGIENIST