YAGASAKI
DENTAL CENTER

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

YAGASAKI
DENTAL CENTER

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? ☐ SOFT ☐ MEDIUM ☐ HARD

	YES	NO
5. Do your gums bleed while brushing?	☐	☐
6. Do your gums bleed while flosing?	☐	☐
7. Do you feel pain to any of your teeth when brushing or flossing them?	☐	☐
8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids?	☐	☐
9. Have you notIced any loosening of your teeth?	☐	☐
10. Does your food tend to become caught between your teeth?	☐	☐
11. Do you have any sores or lumps in or near your mouth?	☐	☐
12 Have you ever experienced any of the following problems in your jaw?		
a. Clicking?	☐	☐
b. Pain (joint, ear, side of face?)	☐	☐
c. Difficulty opening or closing?	☐	☐
d. Difficulty in chewing?	☐	☐
13. Have you everhad any head, neck or jaw injuries?	☐	☐
14. Do you have frequent headaches?	☐	☐
15. Do you clench or grind your teeth while awake or asleep?	☐	☐
16. Do you bite your lips or cheecks frequently?	☐	☐
17. Have you ever had:		
a. Orthodontic treatment (braces)?	☐	☐
b. Oral Surgery?	☐	☐
c. Gum Treatment?	☐	☐
d. Your teeth ground or the bite adjusted?	☐	☐
e. Worn a bite plane or other appliance?	☐	☐
18. Are you satisfied with the appearance of your teeth?	☐	☐
19. Have you ever had an upsetting experience in the dental office?	☐	☐
20. Is there anything about having dental treatment that bothers you?	☐	☐

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
1. Are you in good health?	☐	☐
2. Have there been any changes in your general health in the past year?	☐	☐
3. Date of last physical exam:_____		
4. Physician's Name:_____ Address:_____ Phone #:_____		
5. Are you now under the care of a physician?	☐	☐
6. Have you ever been hospitalized for any surgical operation or serious illness? Please explain:_____	☐	☐

MEDICAL HISTORY (cont.)

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

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:

DATE	COMMENTS	INTIALS PATIENT	DENTIST	HYGIENIST