



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: _____ EXTENSION #: _____
WHERE DO YOU PREFER TO BE REACH? ☐ HOME ☐ WORK ☐ E-MAIL
WHEN IS THE BEST TIME TO REACH YOU? TIME: _____ DAYS: _____
IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT? _____
HOME PHONE: _____
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?	☐ SOFT	☐ MEDIUM	☐ HARD		
	YES	NO		YES	NO
5. Do your gums bleed while brushing?	☐	☐	14. Do you have frequent headaches?	☐	☐
6. Do your gums bleed while flossing?	☐	☐	15. Do you clench or grind your teeth	☐	☐
7. Do you feel pain to any of your teeth when brushing or flossing them?	☐	☐	while awake or asleep?		
8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids?	☐	☐	16. Do you bite your lips or cheeks frequently?	☐	☐
9. Have you noticed any loosening of your teeth?	☐	☐	17. Have you ever had:		
10. Does your food tend to become caught between your teeth?	☐	☐	a. Orthodontic treatment (braces)?	☐	☐
11. Do you have any sores or lumps in or near your mouth?	☐	☐	b. Oral Surgery?	☐	☐
12. Have you ever experienced any of the following problems in your jaw?			c. Gum Treatment?	☐	☐
a. Clicking?	☐	☐	d. Your teeth ground or the bite adjusted?	☐	☐
b. Pain (joint, ear, side of face?)	☐	☐	e. Worn a bite plane or other appliance?	☐	☐
c. Difficulty opening or closing?	☐	☐	18. Are you satisfied with the appearance of your teeth?	☐	☐
d. Difficulty in chewing?	☐	☐	19. Have you ever had an upsetting experience in the dental office?	☐	☐
13. Have you ever had any head, neck or jaw injuries?	☐	☐	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		YES	NO
1. Are you in good health?	☐	☐	5. Are you now under the care of a physician?	☐	☐
2. Have there been any changes in your general health in the past year?	☐	☐	6. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
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 Bisphosphonates medicine? Including non-prescription medicine? If yes, what medicine(s) are you taking? _____	☐	☐	b. Are you ever short of breath after mild exercise?	☐	☐
8. Have you had any abnormal bleeding?	☐	☐	c. Do your ankles swell?	☐	☐
9. Do you bruise easily?	☐	☐	d. Do you get short of breath when you lay down?	☐	☐
10. Have you ever required a blood transfusion	☐	☐	e. Do you require extra pillows when you sleep?	☐	☐
11. Have you had a recent weight loss?	☐	☐	6. Heart surgery?	☐	☐
12. Do you use tobacco products?	☐	☐	7. High blood pressure?	☐	☐
13. Do you use alcohol or cocaine or other drugs?	☐	☐	8. Low blood pressure?	☐	☐
14. Are you wearing contact lenses?	☐	☐	9. Hepatitis, jaundice or liver disease?	☐	☐
15. Do you have any disease, condition or problem not listed above that you think I should know about?	☐	☐	10. Stroke?	☐	☐
<u>FEMALES ONLY:</u>			11. Sinus problems?	☐	☐
1. Are you pregnant or you think may be pregnant?	☐	☐	12. Lung or breathing problems?	☐	☐
2. Are you nursing	☐	☐	13. Asthma or hay fever?	☐	☐
3. Are you taking birth control pills	☐	☐	14. Hives or skin rash?	☐	☐
<u>ARE YOU ALLERGIC TO OR HAD HAVE YOU HAD A REACTION TO:</u>			15. Fainting spells or seizure?	☐	☐
1. Local anesthetic like NOVACAINE?	☐	☐	16. Diabetes?	☐	☐
2. Penicillin or other antibiotics?	☐	☐	17. AIDS or HIV infection?	☐	☐
3. Sulfa Drugs?	☐	☐	18. Thyroid problems?	☐	☐
4. Barbiturates, sedatives or sleeping pills?	☐	☐	19. Allergies?	☐	☐
5. Aspirin?	☐	☐	20. Arthritis or rheumatism?	☐	☐
6. Iodine?	☐	☐	21. Joint replacement or implant?	☐	☐
7. Latex allergy?	☐	☐	22. Stomach ulcer?	☐	☐
8. Other: _____	☐	☐	23. Kidney trouble?	☐	☐
<u>DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:</u>			24. Tuberculosis?	☐	☐
1. Rheumatic heart disease or rheumatic fever?	☐	☐	25. Persistent cough?	☐	☐
2. Scarlet fever?	☐	☐	26. Cancer?	☐	☐
3. Heart defect ot heart murmur?	☐	☐	27. Sexually transmitted disease?	☐	☐
4. Heart trouble, heart attack, or angina?	☐	☐	28. Epilepsy?	☐	☐
a. Do you have pain in your chest?	☐	☐	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:		INITIALS		
DATE	COMMENTS	PATIENT	DENTIST	HYGIENIST