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PATIENT REGISTRATION

Today's Date_____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: _____
☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc. Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2 Section 3

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Employer: _____

Whom may we thank for referring you to our office? _____

Occupation _____

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Authorization

SERVICE CHARGE: If I do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.75% per month (or $1.00 minimum) which is an annual percentage rate of 21.00% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the account due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. **Initial_____**

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals. **Initial_____**

I have reviewed and understand the *Dental Materials Fact Sheet.* **Initial_____**

We reserve the right to charge for appointments cancelled or broken without 48 hours advance notice. **Initial_____**

Signature_____Date_____
☐ ADULT PATIENT ☐ FATHER OR HUSBAND ☐ MOTHER OR WIFE ☐ GUARDIAN

Authorization Updates:

Signature_____Date_____
☐ ADULT PATIENT ☐ FATHER OR HUSBAND ☐ MOTHER OR WIFE ☐ GUARDIAN

Signature_____Date_____
☐ ADULT PATIENT ☐ FATHER OR HUSBAND ☐ MOTHER OR WIFE ☐ GUARDIAN

Signature_____Date_____
☐ ADULT PATIENT ☐ FATHER OR HUSBAND ☐ MOTHER OR WIFE ☐ GUARDIAN

Signature_____Date_____
☐ ADULT PATIENT ☐ FATHER OR HUSBAND ☐ MOTHER OR WIFE ☐ GUARDIAN

Luke H. Iwata, D.D.S.

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Family Medical Doctor (name)_____(phone)_____

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

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

☐ Pregnant/Trying to get pregnant? ☐ Nursing?

☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

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

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Dental Questionnaire

Correct answers to the following questions will allow us to treat you on a more individual basis, providing the care appropriate for your particular needs.

****Emergency Contact** (name)_____(phone)_____(relationship)_____

1. Are you having any discomfort at this time? ☐ Yes ☐ No
2. Have you ever had any serious trouble associated with previous dentistry? ☐ Yes ☐ No
3. Does dental treatment make you nervous? ☐ Yes ☐ No
4. **Name of previous Dentist** _____Phone #_____Date of last visit_____
5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ☐ Yes ☐ No
6. How often do you brush_____.
7. Do you have or have you ever had any of the following:

MOUTH		TEETH	
Bleeding, sore gums	☐ Yes ☐ No	Loose teeth	☐ Yes ☐ No
Unpleasant taste/bad breath	☐ Yes ☐ No	Sensitive to hot	☐ Yes ☐ No
Burning tongue/lips	☐ Yes ☐ No	Sensitive to cold	☐ Yes ☐ No
Frequent blister, lips/mouth	☐ Yes ☐ No	Sensitive to sweets	☐ Yes ☐ No
Swelling/lumps in mouth	☐ Yes ☐ No	Sensitive to biting	☐ Yes ☐ No
Ortho treatments (braces)	☐ Yes ☐ No	Food impaction	☐ Yes ☐ No
Biting cheeks/lips	☐ Yes ☐ No	Clenching/grinding	☐ Yes ☐ No
Clicking/popping jaw	☐ Yes ☐ No	If so, when_____	
Difficulty opening or closing jaw	☐ Yes ☐ No	Shifting in bite	☐ Yes ☐ No
Are you aware that you snore	☐ Yes ☐ No	Change in bite	☐ Yes ☐ No

Do you use the following?

Electric tooth brush	☐ Yes ☐ No	Dental Floss	☐ Yes ☐ No
Fluoride Rinse	☐ Yes ☐ No	Water Pik	☐ Yes ☐ No

These are the things that are important to me about my dental health: _____

_____

What do you fear most about dental care? _____

Circle one:

1. My mouth is
   A. very comfortable
   B. moderately comfortable
   C. uncomfortable
2. I
   A. think the appearance of my mouth is excellent.
   B. am satisfied with the appearance of my mouth.
   C. am dissatisfied with the appearance of my mouth.
3. I
   A. will do anything to keep my natural teeth.
   B. want to keep my teeth, but have a certain budget of time and money.
4. I
   A. have set goals for my oral health with a previous dentist.
   B. want to set goals concerning my dental health.
5. I
   A. have always done the best that was recommended for my dental health
   B. have not done what dentists have recommended to me.
   C. rarely go, and don't care much about having dental work completed.
6. I
   A. have put dentistry for myself & family high on my priority list.
   B. put dentistry for myself & family low on my priority list.
7. I think my present state of dental health is:
   A. Excellent.
   B. Good.
   C. Fair.
   D. Poor.
8. I would like to have whiter teeth
   ☐ Yes ☐ No

This information is true and accurate to the best of my knowledge:

Signature:_____Date:_____