Thank You for Selecting the Dental Office of Dr. David S. Yasuda!

We strive to provide you with the best possible dental care. To help us meet your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

PATIENT INFORMATION [Confidential] Today's Date _____

Name _____ Nickname I'd like to be called _____

SS # _____ Birthdate _____ Home Phone ( ) _____

Address _____ Work Phone ( ) _____

_____ Cell Phone ( ) _____

Email Address _____ Best number to contact you? Home ☐ Work ☐ Cell ☐

Special Interests _____

Check appropriate box:
☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Sex:
☐ Male ☐ Female

If Student, Name of School/College _____ City _____ State _____

Patient's or Parent's Employer _____ Work Phone ( ) _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone ( ) _____

Whom May We Thank for Referring You? _____

Primary Care Physician _____ Phone ( ) _____ Date of Last Visit _____

Pharmacy _____ Phone ( ) _____

Person to Contact in Case of Emergency _____ Phone ( ) _____ Relationship _____

Closest Relative not living with you: _____ Phone ( ) _____ Relationship _____

FINANCIAL ARRANGEMENTS

Payment in full is required at each appointment.

Responsible party for patient:
☐ Self ☐ Spouse ☐ Parent ☐ Other _____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Name of Insured _____
Relationship to Patient _____
SS # _____ Birthdate _____
Employer _____
Insurance Co _____
Ins Co Address _____
_____
Phone No ( ) _____
Group No _____

ADDITIONAL DENTAL COVERAGE? ☐ Yes ☐ No

Name of Insured _____
Relationship to Patient _____
SS # _____ Birthdate _____
Employer _____
Insurance Co _____
Ins Co Address _____
_____
Phone No ( ) _____
Group No _____

HEALTH HISTORY

Please mark Yes or No to each of the following conditions:

Y	N	Condition	Y	N	Condition	Y	N	Condition	Y	N	Condition
☐	☐	Abnormal Bleeding	☐	☐	C. O. P. D.	☐	☐	HPV	☐	☐	Radiation Therapy
☐	☐	Acid Reflux / Ulcers	☐	☐	Colitis	☐	☐	Heart Attack	☐	☐	Rheumatic Fever
☐	☐	Alcohol Abuse	☐	☐	Congenital Heart Defect	☐	☐	Heart Surgery	☐	☐	Seizures
☐	☐	Allergies/Hay Fever	☐	☐	Diabetes	☐	☐	Hemophilia	☐	☐	Shingles
☐	☐	Anemia	☐	☐	Drug Abuse History	☐	☐	Hepatitis A B C	☐	☐	Sickle Cell or Trait
☐	☐	Angina Pectoris	☐	☐	Epilepsy	☐	☐	High Blood Pressure	☐	☐	Sinus Problems
☐	☐	Arthritis	☐	☐	Fainting Spells	☐	☐	High Cholesterol	☐	☐	Sleep Apnea/Snoring
☐	☐	Artificial Heart Valve	☐	☐	Fever Blisters	☐	☐	Kidney Problems	☐	☐	Stroke
☐	☐	Artificial Joint	☐	☐	Fosamax / Boniva	☐	☐	Liver Problems	☐	☐	Taken Redux / Fen-Phen
☐	☐	Asthma	☐	☐	Frequent headaches	☐	☐	Mental Health Treatment	☐	☐	Thyroid problems
☐	☐	Blood Transfusion	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis
☐	☐	Cancer-Chemotherapy	☐	☐	HIV +/AIDS	☐	☐	Pacemaker	☐	☐	

Are you allergic to any of the following? Please mark Yes or No for each:

Y	N		Y	N		Y	N		Y	N		Y	N	
☐	☐	Aspirin	☐	☐	Dental Anesthetics	☐	☐	Jewelry	☐	☐	Metals	☐	☐	Sulfa
☐	☐	Codeine	☐	☐	Erythromycin	☐	☐	Latex	☐	☐	Penicillin	☐	☐	Tetracycline
Other:														

Are you taking any medications? If so, please list below, or provide a list:

Medication	Dose	When Taken	Condition	Medication	Dose	When Taken	Condition

Do you need to take antibiotics prior to dental appointments? ☐ Yes ☐ No
If yes, please explain: _____
Medication/Dosage: _____

Do you smoke or chew tobacco? ☐ Yes ☐ No
If yes, what product (i.e. cigarette, cigar, e-cigarette, vaporizer, marijuana)? _____
How frequently? _____

WOMEN ONLY
Are you taking birth control pills? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No
If yes, what week? _____
Are you nursing? ☐ Yes ☐ No

Do you have any other disease or medical condition we should be aware of? ☐ Yes ☐ No
If yes, please explain: _____

DENTAL HISTORY

Are you in pain now? ☐ Yes ☐ No If yes, where? _____ For how long? _____
Reason for today's visit _____
Last Dental Cleaning _____ / _____ /_____ Last X-rays _____ / _____ / _____ Last dentist: _____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the dental office of any changes in my medical status and/or other information. I authorize the dentist to take radiographs, study models, photographs, or any other diagnostics aids deemed appropriate by Dr. Yasuda, with patient's consent, to make a thorough diagnosis of the patient's dental needs. I authorize the dental team at Dr. David Yasuda's to release information such as the diagnosis and the records of any treatment or examination, during the period of such dental care to third party payers and/or other health practitioners. I understand that my dental insurance carrier may pay less than the actual fee for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature _____ Date _____ Relationship to Patient _____