

Welcome

Dental Registration and History

PATIENT INFORMATION

Today's Date _____

Patient Name _____

Address _____

City _____ State _____ Zip _____

Gender F M Marital Status _____

SS# _____ Date of Birth _____

Phone h _____ w _____

c _____ o _____

Best time and place to reach you? _____

Email _____

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone _____

Spouse or Emergency Contact Information

Name _____

SS# _____ Date of Birth _____

Relationship _____

Phone h _____ w _____

c _____ o _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Insurance Co. _____

Subscriber Name _____

Subscriber Date of Birth _____

Subscriber # _____ Group # _____

Relationship to Patient _____

Is patient covered by additional insurance? Y N

Insurance Co. _____

Subscriber Name _____

Subscriber Date of Birth _____

Subscriber # _____ Group # _____

Relationship to Patient _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____

Name of Insurance Company(ies)

and assign directly to **Kevin S. Sugiki D.D.S, LLC** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Signature of Patient, Parent, Guardian or Personal Representative

Print name of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

Date of last dental exam, cleaning, X-rays _____

How often do you floss? _____

How often do you brush? _____

Do you require antibiotics before dental treatment? _____

Place a mark on "yes" or "no" to indicate if you have, or have had, any of the following:

- | | | | |
|-----------------------------------|---|--------------------------------|---|
| Bleeding gums | <input type="checkbox"/> Y <input type="checkbox"/> N | Mouth pain, brushing | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Cigarette, pipe, or cigar smoking | <input type="checkbox"/> Y <input type="checkbox"/> N | Orthodontic treatment | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Clicking or popping jaw | <input type="checkbox"/> Y <input type="checkbox"/> N | Periodontal treatment | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Dry mouth | <input type="checkbox"/> Y <input type="checkbox"/> N | Sensitivity to cold | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Grinding teeth | <input type="checkbox"/> Y <input type="checkbox"/> N | Sensitivity to heat | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Gums swollen or tender | <input type="checkbox"/> Y <input type="checkbox"/> N | Sensitivity to sweets | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Jaw pain | <input type="checkbox"/> Y <input type="checkbox"/> N | Sensitivity when biting | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Loose teeth or broken fillings | <input type="checkbox"/> Y <input type="checkbox"/> N | Sores or growths in your mouth | <input type="checkbox"/> Y <input type="checkbox"/> N |

MEDICAL HISTORY

Physician's Name _____

Date of last visit _____

Have you ever taken any weight loss medication? Y N

Have you ever been hospitalized or had a major operation? Y N

If yes, please explain _____

Place a mark on "yes" or "no" to indicate if you have, or have had, any of the following:

AIDS/HIV Positive	<input type="checkbox"/> Y <input type="checkbox"/> N	Jaw Pain	<input type="checkbox"/> Y <input type="checkbox"/> N
Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Arthritis, Rheumatism	<input type="checkbox"/> Y <input type="checkbox"/> N	Liver Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Artificial Heart Valves	<input type="checkbox"/> Y <input type="checkbox"/> N	Low Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N
Artificial Joints	<input type="checkbox"/> Y <input type="checkbox"/> N	Mitral Valve Problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	Osteoporosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Back Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N
Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	Psychiatric Care	<input type="checkbox"/> Y <input type="checkbox"/> N
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Y <input type="checkbox"/> N	Radiation Treatment	<input type="checkbox"/> Y <input type="checkbox"/> N
Blood Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Respiratory Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Chemical Dependency	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatic Fever	<input type="checkbox"/> Y <input type="checkbox"/> N
Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N	Scarlet Fever	<input type="checkbox"/> Y <input type="checkbox"/> N
Circulatory Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N
Congenital Heart Lesions	<input type="checkbox"/> Y <input type="checkbox"/> N	Shortness of Breath	<input type="checkbox"/> Y <input type="checkbox"/> N
Cortisone Treatments	<input type="checkbox"/> Y <input type="checkbox"/> N	Shingles	<input type="checkbox"/> Y <input type="checkbox"/> N
Cough, persistent or bloody	<input type="checkbox"/> Y <input type="checkbox"/> N	Sinus Trouble	<input type="checkbox"/> Y <input type="checkbox"/> N
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Skin Rash	<input type="checkbox"/> Y <input type="checkbox"/> N
Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N	Special Diet	<input type="checkbox"/> Y <input type="checkbox"/> N
Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N	Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N
Fainting or dizziness	<input type="checkbox"/> Y <input type="checkbox"/> N	Swollen Feet or Ankles	<input type="checkbox"/> Y <input type="checkbox"/> N
Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N	Swollen Neck Glands	<input type="checkbox"/> Y <input type="checkbox"/> N
Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N	Thyroid Problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N	Tonsillitis	<input type="checkbox"/> Y <input type="checkbox"/> N
Heart Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Hepatitis Type _____	<input type="checkbox"/> Y <input type="checkbox"/> N	Tumor or growth on head or neck	<input type="checkbox"/> Y <input type="checkbox"/> N
Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N	Ulcer	<input type="checkbox"/> Y <input type="checkbox"/> N
High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	Venereal Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Jaundice	<input type="checkbox"/> Y <input type="checkbox"/> N	Weight Loss	<input type="checkbox"/> Y <input type="checkbox"/> N

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone _____

ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Iodine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Barbiturate	<input type="checkbox"/> Latex	<input type="checkbox"/> Valium
<input type="checkbox"/> Codeine	<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Vicodin
<input type="checkbox"/> Darvon	<input type="checkbox"/> Metals	<input type="checkbox"/> Other
<input type="checkbox"/> Demerol	<input type="checkbox"/> Nitrous Oxide	_____
<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Penicillin	_____

WOMEN

Are you pregnant? Y N

How many weeks? _____

Are you taking birth control pills? Y N

Are you nursing? Y N

GENERAL CONSENT FOR SERVICES and MISSED APPOINTMENT POLICY

I hereby give my consent to undergo the dental treatment deemed necessary or advisable in the opinion of Dr. Kevin S. Sugiki, as consulted. If he determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

We reserve your appointment time especially for you and we make every effort to see our patients in a timely manner. If for any reason you cannot make your scheduled appointment, we request that you contact our office with 24 hours. Patients who cancel or fail to show up for a scheduled appointment without 24 hour notice will be charged \$40.00. If you have any questions about our policy, please do not hesitate to contact our office.

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Signature of Patient, Parent, Guardian or Personal Representative

Print name of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices.

Signature of Patient, Parent, Guardian or Personal Representative

Print name of Patient, Parent, Guardian or Personal Representative

Date