Kevin S. Sugiki D.D.S., LLC

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	☐Y ☐N	Mouth pain, brushing	☐Y ☐N
Cigarette, pipe, or cigar smoking	☐Y ☐N	Orthodontic treatment	☐Y ☐N
Clicking or popping jaw	☐Y ☐N	Periodontal treatment	☐Y ☐N
Dry mouth	☐Y ☐N	Sensitivity to cold	☐Y ☐N
Grinding teeth	☐Y ☐N	Sensitivity to heat	☐Y ☐N
Gums swollen or tender	☐Y ☐N	Sensitivity to sweets	☐Y ☐N
Jaw pain	☐Y ☐N	Sensitivity when biting	☐Y ☐N
Loose teeth or broken fillings	☐Y ☐N	Sores or growths in your mouth	☐Y ☐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	☐Y ☐N	Jaw Pain	☐Y ☐N
Anemia	☐Y ☐N	Kidney Disease	☐Y ☐N
Arthritis, Rheumatism	☐Y ☐N	Liver Disease	☐Y ☐N
Artificial Heart Valves	☐Y ☐N	Low Blood Pressure	☐Y ☐N
Artificial Joints	☐Y ☐N	Mitral Valve Problems	☐Y ☐N
Asthma	☐Y ☐N	Osteoporosis	☐Y ☐N
Back Problems	☐Y ☐N	Pacemaker	☐Y ☐N
Cancer	☐Y ☐N	Psychiatric Care	☐Y ☐N
Bleeding abnormally, with extractions or surgery	☐Y ☐N	Radiation Treatment	☐Y ☐N
Blood Disease	☐Y ☐N	Respiratory Disease	☐Y ☐N
Chemical Dependency	☐Y ☐N	Rheumatic Fever	☐Y ☐N
Chemotherapy	☐Y ☐N	Scarlet Fever	☐Y ☐N
Circulatory Problems	☐Y ☐N	Seizures	☐Y ☐N
Congenital Heart Lesions	☐Y ☐N	Shortness of Breath	☐Y ☐N
Cortisone Treatments	☐Y ☐N	Shingles	☐Y ☐N
Cough, persistent or bloody	☐Y ☐N	Sinus Trouble	☐Y ☐N
Diabetes	☐Y ☐N	Skin Rash	☐Y ☐N
Emphysema	☐Y ☐N	Special Diet	☐Y ☐N
Epilepsy	☐Y ☐N	Stroke	☐Y ☐N
Fainting or dizziness	☐Y ☐N	Swollen Feet or Ankles	☐Y ☐N
Glaucoma	☐Y ☐N	Swollen Neck Glands	☐Y ☐N
Headaches	☐Y ☐N	Thyroid Problems	☐Y ☐N
Heart Murmur	☐Y ☐N	Tonsillitis	☐Y ☐N
Heart Problems	☐Y ☐N	Tuberculosis	☐Y ☐N
Hepatitis Type _____	☐Y ☐N	Tumor or growth on head or neck	☐Y ☐N
Herpes	☐Y ☐N	Ulcer	☐Y ☐N
High Blood Pressure	☐Y ☐N	Venereal Disease	☐Y ☐N
Jaundice	☐Y ☐N	Weight Loss	☐Y ☐N

MEDICATIONS

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

_____

_____

_____

_____

_____

Pharmacy Name_____

Phone_____

ALLERGIES

☐Aspirin	☐Iodine	☐Sulfa
☐Barbiturate	☐Latex	☐Valium
☐Codeine	☐Local Anesthetic	☐Vicodin
☐Darvon	☐Metals	☐Other
☐Demerol	☐Nitrous Oxide	_____
☐Erythromycin	☐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