Patrick T. Yoshikane, DDS

Welcome to Our Office

PERSONAL INFORMATION

Date: _____

Name: _____ Gender ☐ M ☐ F Age:_____ DOB: _____

Address: _____ City: _____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email: _____

Drivers Lic. #: _____ SS#: _____ Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Patient Employer/School:_____ Occupation: _____

Address: _____ City: _____ State:_____ Zip:_____

Employer/School Phone: _____

Name of Spouse: _____ SS#: _____ Cell Phone:_____
(responsible party if minor)

Spouse Employer:_____ Work Phone:_____

Address: _____ City: _____ State:_____ Zip:_____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship:_____ Phone: _____

Name: _____ Relationship:_____ Phone: _____

Who is your PHYSICIAN? _____ Phone #: _____

DENTAL INSURANCE AND FINANCIAL INFORMATION

Responsible Party: _____ DOB: _____

Relationship to Patient: _____ Phone Number: _____ SS#: _____

Insurance Carrier:_____ Group #: _____ ID#: _____

SECONDARY INSURANCE INFORMATION

Is patient covered by additional insurance? ☐ Yes ☐ No

Responsible Party: _____ DOB: _____

Relationship to Patient: _____ Phone Number: _____ SS#: _____

Insurance Carrier:_____ Group #: _____ ID#: _____

ASSIGNMENT AND RELEASE OF BENEFITS

We invite you to discuss with us any questions regarding our services. The best dental health services are based on friendly, mutual understanding between provider and patient. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Patrick T. Yoshikane, DDS, 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. The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature:_____ ☐ Adult Patient ☐ Parent or Guardian ☐ Spouse Date: _____

DENTAL HEALTH HISTORY

Reason for today's visit:_____ Previous dentist:_____ Last dental visit: _____

Check any of the following which you have had or have at present:

	YES	NO		YES	NO		YES	NO
Bad Breath	❑	❑	Grinding teeth	❑	❑	Pain around ear	❑	❑
Bleeding Gums	❑	❑	Gums swollen or tender	❑	❑	Periodontal treatment	❑	❑
Burning sensation on tongue	❑	❑	Lip or cheek biting	❑	❑	Sensitivity to cold	❑	❑
Chew on one side of mouth	❑	❑	Loose teeth or broken fillings	❑	❑	Sensitivity to heat	❑	❑
Dry Mouth	❑	❑	Mouth breathing	❑	❑	Sensitivity to sweets	❑	❑
Fingernail biting	❑	❑	Mouth pain, brushing	❑	❑	Sensitivity when biting	❑	❑
Food collection between teeth	❑	❑	Orthodontic treatment	❑	❑			

How often do you brush your teeth?_____ How often do you floss? _____

See other side>>>>>

MEDICAL HEALTH HISTORY

1) Have you been under the care of a medical doctor during the past two years? ☐ No ☐ Yes, explain:_____

2) Have you been a patient in the hospital during the past two years? ☐ No ☐ Yes, explain:_____

3) Please rate your general health from 1 to 10 (with 10 being the healthiest)_____ WOMEN: Are you pregnant? ☐ No ☐ Yes

4) Are you allergic (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, latex or any drugs or medications? ☐ No ☐ Yes _____

5) Have you ever taken Phen-fen or Redux? ☐ No ☐ Yes Are you currently taking Bisphosphonate/Fosamax? ☐ No ☐ Yes

6) Please list any medications you are currently taking (including herbal supplements) _____

_____

7) Check any of the following which you have had or have at present:

CARDIOLOGY	YES	NO
Heart Failure	❑	❑
Heart Attack	❑	❑
Heart Defects	❑	❑
Angina Pectoris	❑	❑
High Blood Pressure	❑	❑
Low Blood Pressure	❑	❑
Heart Murmur	❑	❑
Rheumatic Fever	❑	❑
Congenital Heart Lesions	❑	❑
Scarlet Fever	❑	❑
Artificial Heart Valve	❑	❑
MVP (Mitrovalve Prolapse)	❑	❑
Pacemaker / Defibrillator	❑	❑
Heart Surgery	❑	❑
Hardening of Arteries	❑	❑
Family History of Heart Disease	❑	❑
Stroke	❑	❑

UROLOGY		
Kidney Trouble / Disease	❑	❑
Liver Disease	❑	❑
Bladder Disease	❑	❑

GASTROENTEROLOGY		
Stomach Problems or Ulcers	❑	❑
Eating Disorders	❑	❑
Digestive Problems	❑	❑
Intestinal Infection	❑	❑

EARS, NOSE & THROAT	YES	NO
Loss of Hearing	❑	❑
Ear Infection	❑	❑
Allergies or Hives	❑	❑
Asthma	❑	❑
Breathing Problems	❑	❑
Sinus Problems	❑	❑
Snoring	❑	❑
Emphysema	❑	❑
Cough	❑	❑
Hay / Scarlet Fever	❑	❑
Rheumatic Fever	❑	❑
Thyroid Disease	❑	❑

SKIN		
Acne	❑	❑
Skin Rash	❑	❑
Shingles	❑	❑

PSYCHIATRIC		
Anxiety	❑	❑
Depression	❑	❑
Nervousness	❑	❑
Psychiatric Treatment	❑	❑
Fainting / Dizziness	❑	❑
Epilepsy or Seizures	❑	❑
Frequent Headaches	❑	❑

BLOOD THINNERS		
Warfarin (Coumadin)	❑	❑
Clopidogrel (Plavix)	❑	❑
Aspirin	❑	❑

DISEASE	YES	NO
AIDS	❑	❑
Hepatitis A	❑	❑
Hepatitis B	❑	❑
Hepatitis C	❑	❑
Yellow Jaundice	❑	❑
Blood Transfusion	❑	❑
Anemia	❑	❑
Leukemia	❑	❑
Tuberculosis	❑	❑
Hemophilia	❑	❑
Venereal Disease	❑	❑
Cold Sores	❑	❑
Genital Herpes	❑	❑
Canker Sores	❑	❑

ARTICULATION-MUSCLES		
Rheumatism	❑	❑
Osteoporosis	❑	❑
Arthritis	❑	❑
Artificial Joints	❑	❑
Jaw Problems / TMJ	❑	❑
Pain in Jaw	❑	❑

TREATMENT		
Chemotherapy	❑	❑
Radiation Treatment	❑	❑
Cortisone Treatment	❑	❑
X-ray or Cobalt Treatment	❑	❑

8) Do you have any disease or condition not listed? ☐ No ☐ Yes, explain: _____

9) Do you use tobacco? ☐ Yes ☐ No How much?_____ Are you using recreational drugs? ☐ No ☐ Yes, explain: _____

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor, or his staff, at the next appointment without fail.

Signature:_____ Date:_____ Dentist/Hygienist Signature: _____

MEDICAL UPDATES

I have reviewed my Medical Health History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dentist Initials
_____	_____	_____	_____
_____	_____	_____	_____