GARY YONEMOTO, DDS
WADE NOBUHARA, DDS

THE FOLLOWING CONFIDENTIAL INFORMATION IS FOR OUR RECORDS ONLY. PLEASE PRINT.

PATIENT INFORMATION

Dr./Mr./Mrs./Ms.

_____ Age _____
Patient's First Name Middle Initial Last Name

Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

Home Address _____

City _____ State _____ Zip Code _____

Birthdate ____/____/____ Soc. Sec. No. _____ Phone _____

Employed By _____ Occupation _____

Business Address _____ Bus. Phone _____

City _____ State _____ Zip Code _____

If Student - School _____ Full Time _____ Part Time _____

If Minor, Person Legally Responsible _____ Phone _____

Whom to Notify In Case of Emergency _____ Phone _____

Relationship _____ Bus. Phone _____

INSURANCE INFORMATION

Name of Dental Insurance Company _____

Insurance Subscriber's Name if Other Than Patient:

_____
First Name Middle Name Last Name

Address _____

City _____ State _____ Zip Code _____

Birthdate ____/____/____ Soc. Sec. No. _____ Phone _____

Employed By _____ Occupation _____

Business Address _____ Bus. Phone _____

Name of Dental Insurance Company if Dual Coverage _____

Ins. Subscriber's Name _____

Address _____

City _____ State _____ Zip Code _____

Birthdate ____/____/____ Soc. Sec. No. _____ Phone _____

Employed By _____ Occupation _____

Business Address _____ Bus. Phone _____

I understand that the total payment of the fee for dental services is my responsibility and not that of the insurance company. As a courtesy, insurance forms will be completed without charge.

I also understand that root canal treatment is an attempt to retain a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment, surgery, or even extraction.

HEALTH HISTORY

The following information is essential for this office to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your dental needs safely and efficiently. Incorrect information can be dangerous to your health.

NOTE: A change in your health status should be reported to this office at the earliest possible time.

Name of Family Physician: Dr. _____ Phone _____

Name of General Dentist: Dr. _____ Phone _____

Other Dental Specialists you have consulted with, if any _____

PLEASE ANSWER EACH QUESTION. **Circle Answer**

Are you in good health? ..... Yes No

If not, explain _____

Are you currently under the care of a physician? ..... Yes No

If yes, for what condition? _____

Name of Physician: Dr. _____ Phone _____

Have you been hospitalized in the last 6 months? ..... Yes No

If yes, for what reason or condition? _____

Are you allergic to penicillin, codeine or other drugs? ..... Yes No

If yes, which? _____

Are you allergic to Latex? ..... Yes No

Are you taking diet pills? ..... Yes No

Do you have a history of blood disorders, abnormal bleeding or bruising? .... Yes No

If yes, which? _____

Do you have a history of heart disease, heart murmur, liver trouble, ulcers, rheumatic fever, diabetes, high blood pressure, prosthetic heart valve or artificial joints? Any serious illness or health problems? ..... Yes No

If yes, explain? _____

Do you have or have you ever been exposed to hepatitis, tuberculosis, venereal disease or AIDS? ..... Yes No

If yes, explain? _____ year 19____

Are you taking any medication at present? ..... Yes No

Name of medication(s) _____

What condition(s) is being treated _____

Female Patients:
Months Pregnant _____ Obstetrician _____
Name Phone

To the best of my knowledge, the foregoing questions have been accurately answered.

Date ____/____/____ Signature _____