Today's date:_____

Patient Information for Children

kanemaru Family Dental

First name: _____ Middle initial: ____ Last name: _____

I prefer to be called (nickname) _____ ___ Male ___ Female Date of birth: _____

Address: _____ City/Zip code: _____

Parent's/Guardian's names (first & last): _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____

Is it okay to correspond w/you via text? ___ Yes ___ No Is it okay to correspond w/you via email? ___ Yes ___ No

Employer: _____ Occupation: _____

Whom may we thank for referring you? _____

If applicable, when is your approximate PCS date? _____

Person to contact in case of an emergency

Name: _____ Relationship: _____

Home #: _____ Work #: _____ Cell #: _____

Dental Insurance

Primary Carrier

Insurance name: _____ Phone #: _____

Subscriber's name: _____ Subscriber ID #: _____

Subscriber's date of birth: _____ Subscriber's relationship to patient: _____

Secondary Carrier

Insurance name: _____ Phone #: _____

Subscriber's name: _____ Subscriber ID #: _____

Subscriber's date of birth: _____ Subscriber's relationship to patient: _____

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to Kanemaru Family Dental insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment or examination rendered, to my insurance company. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to the respective healthcare provider or agency that may release such information to you. I will notify Dr. Kanemaru of any changes in my health or medication.

Signature: _____ Date: _____

FOR OFFICE USE:

Date: _____ Initial: _____ Changes: _____

Date: _____ Initial: _____ Changes: _____

Date: _____ Initial: _____ Changes: _____

Date: _____ Initial: _____ Changes: _____

Date: _____ Initial: _____ Changes: _____

Date: _____ Initial: _____ Changes: _____

Date: _____ Initial: _____ Changes: _____

Medical History

Have you been hospitalized or under the care of a medical doctor during the past 2 years? ___ Yes ___ No If YES, for what?_____

Physician's name:_____ Phone:_____

Are you currently taking any medications or drugs? ___ Yes ___ No If YES, Please List: _____

_____

_____

_____

Do you have heart problems? ___ Yes ___ No If YES, please specify:_____

Do you smoke/use tobacco? ___ Yes ___ No If YES, how many per day? _____

For Women: Are you pregnant or think that you may be pregnant?___Yes ___ No if YES, what month?_____

Please check either "Yes" or "No" for each of the following

Indicate which of the following you have had or have at present:

Surgeries:		Cancer/ Chemotherapy		Kidney Trouble	
Heart	___Yes___No	Chest Pain	___Yes ___No	Liver Disease	___Yes ___No
Joint/bone surgery	___Yes___No	Cold Sores/ Herpes	___Yes ___No	Lupus	___Yes___No
Joint Replacement	___Yes ___No	Colitis	___Yes ___No	Nervousness/Anxiety	___Yes___No
Heart (Disease, Attack)	___Yes___No	Cortisone Medicine	___Yes ___No	Neurological Disorders	___Yes___No
Mitral Valve Prolapse	___Yes___No	Difficulty Breathing	___Yes___No	Psychiatric /Psychological Care	___Yes___No
Heart Murmur	___Yes___No	Drug Addiction	___Yes ___No	Radiation Therapy	___Yes___No
Heart Pacemaker	___Yes___No	Eating Disorder	___Yes ___No	Rheumatic/Scarlet Fever	___Yes___No
Artificial Heart Valve	___Yes ___No	Emphysema	___Yes___No	Shingles/ Chicken Pox	___Yes___No
Diabetes	___Yes ___No	Epilepsy or Seizures	___Yes___No	Sickle Cell Disease/Traits	___Yes___No
Allergies or Hives	___Yes ___No	Fainting or Dizzy Spells	___Yes___No	Sinus Trouble	___Yes___No
AIDS / HIV	___Yes ___No	Frequent Headaches	___Yes___No	Snoring/Sleep Apnea	___Yes___No
Alcohol Addiction	___Yes ___No	Glaucoma	___Yes___No	Stomach Problems/ Ulcers	___Yes___No
Anemia	___Yes ___No	Hay Fever	___Yes___No	Stroke	___Yes___No
Arthritis / Rheumatism	___Yes ___No	Hemophilia/Abnormal Bleeding	___Yes___No	Thyroid Problems	___Yes___No
Asthma	___Yes ___No	Hepatitis A B C	___Yes___No	Tuberculosis (TB)	___Yes___No
Blood Disease	___Yes ___No	High Cholesterol	___Yes___No	Tumors	___Yes___No
Blood Transfusion	___Yes ___No	High or Low Blood Pressure	___Yes___No	Other: _____	
Bruise Easily	___Yes ___No	Jaundice	___Yes___No	_____	

Has your child received all reccomended medical vacinations? __ Yes __ No

Are you aware of having an allergic (or adverse) reaction to any of the following:

Aspirin	___Yes ___No	Erythromycin	___Yes ___No	Sedatives	___Yes___No
Codeine	___Yes ___No	Iodine	___Yes ___No	Sulfa Drugs	___Yes___No
Anesthetics (ex. Novocaine)	___Yes ___No	Jewelry/Metals	___Yes ___No	Tetracycline	___Yes___No
Penicillin	___Yes ___No	Latex	___Yes ___No	Other: _____	

Is there anything you would like Dr. Kanemaru to know that would assist us in providing you with outstanding care? (Example: "I gag easily ...do not recline me too far ...")

_____

_____

_____

_____

_____