kanemaru Family Dental

Patient Information

Today's date:_____

First name:_____ Middle initial:_____ Last name:_____
I prefer to be called (nickname, etc.)_____ ___ Male ___ Female ___Single ___Married ___Other
Address:_____ City:_____
Date of birth:_____ Social security no._____
Home phone:_____ Work phone:_____ Cell phone:_____
Email:_____ Driver's license no._____
Employer:_____ Occupation:_____
(If applicable:)
Spouse's name:_____ Spouse's contact phone: _____
Spouse's Employer:_____ Occupation:_____
Whom may we thank for referring you? _____

Person to contact in case of emergency
Name:_____ Relationship:_____
Home phone:_____ Work phone:_____ Cell phone:_____

Dental Insurance

Primary Carrier
Insurance co.name:_____ Phone no.:_____
Insured's name:_____ Insured's I.D. no._____
Insured's date of birth:_____ Insured's Relationship to patient:_____
Secondary Carrier
Insurance co.name:_____ Phone no.:_____
Insured's name:_____ Insured's I.D. no._____
Insured's date of birth:_____ Insured'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 knopwledge. Should further information be needed, you have my permission to the the respective healthcare provider or agency that may release such information for 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:_____

Medical History

Have you been hospitalized or under the care of a medical doctor during the past 2 years? _____ 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 much? _____

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

Are you nursing? ___ Yes ___ No Are you taking birth control pills? ___ Yes ___ No

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

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

AIDS/HIV	___ Yes ___ No	Difficulty Breathing	___ Yes ___ No	Neurological Disorders	___ Yes ___ No
Alcohol Addiction	___ Yes ___ No	Emphysema	___ Yes ___ No	Pychiatric/Psychological Care	___ Yes ___ No
Drug Addiction	___ Yes ___ No	Epilepsy or Seizures	___ Yes ___ No	Radiation Therapy	___ Yes ___ No
Allergies or Hives	___ Yes ___ No	Fainting or Dizzy Spells	___ Yes ___ No	Rheumatic/Scarlet Fever	___ Yes ___ No
Anemia	___ Yes ___ No	Frequent Headaches	___ Yes ___ No	Shingles/Chicken Pox	___ Yes ___ No
Arthritis/Rheumatism	___ Yes ___ No	Glaucoma	___ Yes ___ No	Sickle Cell Disease/Traits	___ Yes ___ No
Artificial Heart Valve	___ Yes ___ No	Hay Fever	___ Yes ___ No	Sinus Trouble	___ Yes ___ No
Joint Replacement	___ Yes ___ No	Heart (Surgery,Disease,Attack)	___ Yes ___ No	Snoring/Sleep Apnea	___ Yes ___ No
Asthma	___ Yes ___ No	Heart Pacemaker	___ Yes ___ No	Stomach Problems/Ulcers	___ Yes ___ No
Blood Disease	___ Yes ___ No	Heart Murmur	___ Yes ___ No	Stroke	___ Yes ___ No
Blood Transfusion	___ Yes ___ No	Hemophilia/Abnormal Bleeding	___ Yes ___ No	Thyroid Problems	___ Yes ___ No
Bruise Easily	___ Yes ___ No	Hepatitis A B C	___ Yes ___ No	Tuberculosis (TB)	___ Yes ___ No
Cancer/Chemotherapy	___ Yes ___ No	High / Low Blood Pressure	___ Yes ___ No	Tumors	___ Yes ___ No
Chest Pain	___ Yes ___ No	Jaundice	___ Yes ___ No	High Cholesterol	___ Yes ___ No
Cold Sores/Herpes	___ Yes ___ No	Kidney Trouble	___ Yes ___ No	Other: _____	
Colitis	___ Yes ___ No	Liver Disease	___ Yes ___ No	_____	
Cortisone Medicine	___ Yes ___ No	Lupus	___ Yes ___ No		
Diabetes	___ Yes ___ No	Mitral Valve Prolapse	___ Yes ___ No		
Eating Disorder	___ Yes ___ No	Nervousness/Anxiety	___ 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 (i.e. Novocaine)	___ Yes ___ No	Jewelry/Metals	___ Yes ___ No	Tetracycline	___ Yes ___ No
		Latex	___ Yes ___ No	Other: _____	
		Penicillin	___ Yes ___ No		

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...")

_____

_____

_____