ALOHA FAMILY DENTAL – DENTAL REGISTRATION

Wayne K. Tsutsuse, DDS - 1020 Suncast Lane, Suite 103, El Dorado Hills, CA 95762 – 916-941-2447

We Would Like to Get to Know You Better!

Full Name _____

Ph # (Hm) _____ (Wk) _____

Cell_____ E-mail _____

Address_____ Apt #_____

City _____ State ____ Zip _____

Male□ Female□ Age_____ Date of Birth _____

Married □ Single □ Minor □ Separated □ Divorced □

SS # _____ Drivers Lic # _____

If minor, child lives with: Mother □ Father □ Both □

Emp/School _____

Emp. Add _____

Wk Ph # _____ Occ. _____

Spouse or Parent Information

Spouse/Parent Name: _____

Emp. & Add.: _____

Work number: _____ DL# _____

Birth Date: _____ S.S. # _____

Who May We Thank For Referring You?

Name _____

Advertisements: Village Life□ Fol/EDH Style□
Serrano Mag □ Yellow Pages □ Other □

Emergency Information

IN CASE OF EMERGENCY, PLEASE CONTACT
(Specify someone who does not live in your household)

Name: _____ Relationship: _____

Home # _____ Work/Cell # _____

Dental Insurance and Financial Information

PRIMARY DENTAL INSURANCE

Dental Insurance Co. _____

Insurance Co. Address _____

Group # _____Phone # _____

Insured's Name _____

Relationship to patient _____

Birth Date _____ Insured's SS# _____

SECONDARY DENTAL INSURANCE

Is patient covered by additional insurance? Yes□ No□

Dental Insurance Co. _____

Insurance Co. Address _____

Group # _____Phone # _____

Insured's Name _____

Relationship to patient _____

Birth Date _____ Insured's SS# _____

ASSIGNMENT AND RELEASE - I certify that I, and/or my dependent(s) have insurance coverage with: (Company(ies) name) _____ and assign directly to Wayne K. Tsutsuse, DDS, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that all charges are charged directly to me and that I am responsible for payment of my account regardless of insurance payment. I understand that it is my responsibility to know and understand my dental benefits and to keep your office up to date on any changes. 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 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.

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility **to inform this office of any changes in my home/employer addresses and to my medical/dental status.**

_____ _____
Signature of Patient, Parent, Guardian or Personal Rep. Date

_____ _____
Print name of Patient, Parent, Guardian or Personal Rep. Relationship

1. Health History

Physician's Name_____ Phone # (____) _____ Date of last visit_____

Have you ever taken OR are you presently taking any of the group of drugs collectively referred to as "Bisphosphonates" ? These include Fosamax, Boniva, and other medications to treat Osteoporosis. ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	___Yes	___No	Epilepsy	___Yes	___No	Respiratory Disease	___Yes	___No
Anemia	___Yes	___No	Fainting or dizziness	___Yes	___No	Rheumatic Fever	___Yes	___No
Arthritis, Rheumatism	___Yes	___No	Glaucoma	___Yes	___No	Scarlet Fever	___Yes	___No
Artificial Heart Valves	___Yes	___No	Headaches	___Yes	___No	Seizures	___Yes	___No
Artificial Joints	___Yes	___No	Heart Murmur	___Yes	___No	Shortness of Breath	___Yes	___No
Asthma	___Yes	___No	Heart Problems	___Yes	___No	Sinus Trouble	___Yes	___No
Back Problems	___Yes	___No	Hepatitis Type_____	___Yes	___No	Skin Rash	___Yes	___No
Bleeding abnormally, with extractions or surgery	___Yes	___No	Herpes	___Yes	___No	Special Diet	___Yes	___No
			High Blood Pressure	___Yes	___No	Stroke	___Yes	___No
Blood Disease	___Yes	___No	Jaundice	___Yes	___No	Swollen Feet or Ankles	___Yes	___No
Cancer	___Yes	___No	Jaw Pain	___Yes	___No	Swollen Neck Glands	___Yes	___No
Chemical Dependency	___Yes	___No	Kidney Disease	___Yes	___No	Thyroid Problems	___Yes	___No
Chemotherapy	___Yes	___No	Liver Disease	___Yes	___No	Tonsillitis	___Yes	___No
Circulatory Problems	___Yes	___No	Low Blood Pressure	___Yes	___No	Tuberculosis	___Yes	___No
Congential Heart Lesions	___Yes	___No	Mitral Valve Prolapse	___Yes	___No	Tumor or growth on head or neck	___Yes	___No
Cortisone Treatments	___Yes	___No	Nervous Problems	___Yes	___No			
Cough, persistent or bloody	___Yes	___No	Pacemaker	___Yes	___No	Ulcer	___Yes	___No
Diabetes	___Yes	___No	Psychiatric Care	___Yes	___No	Venereal Disease	___Yes	___No
Emphysema	___Yes	___No	Radiation Treatment	___Yes	___No	Weight Loss, unexplained	___Yes	___No

Women: Are you pregnant? ___Yes ___No Due date_____ Are you nursing _____ Taking birth control pills?_____

Do you need to be **PREMEDICATED WITH ANTIBIOTICS** before dental treatment? _____YES _____NO

2. Medications

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

_____

Pharmacy Name _____

City_____ Phone # (____) _____

3. Allergies

☐ Aspirin
☐ Barbiturates (Sleeping Pills)
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other _____
_____

4. Dental History

Reason for today's visit _____

_____

Former Dentist_____

City/State_____

Date of last dental visit_____

Date of last dental x-rays_____

Do you like your smile?_____

Circle if you have any of the following:

Bad breath
Bleeding gums
Blisters on lips or mouth
Burning sensation on tongue
Chew on one side of mouth
Cigarette, pipe, or cigar smoking
Clicking or popping jaw
Dry mouth
Fingernail biting
Food collection between the teeth
Grinding teeth
Gums swollen or tender
Lip or cheek biting
Loose teeth or broken fillings
Mouth breathing
Mouth pain while brushing
Orthodontic treatment
Pain around ear
Periodontal treatment
Sensitivity to cold/heat/sweets/pressure
Sores or growths in your mouth
How often do you floss?_____
How often do you brush:_____

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_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date