

ALOHA FAMILY DENTAL – DENTAL REGISTRATION

Wayne K. Tsutsuse, DDS - 1020 Suncastr 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

PATIENT'S NAME _____

Physician's Name _____ Phone # (____) _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine). Pondimin (fenfluramine) and Redux (dexfenfluramine). 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 |
| Blood Disease | ___ Yes ___ No | High Blood Pressure | ___ Yes ___ No | Stroke | ___ Yes ___ No |
| Cancer | ___ Yes ___ No | Jaundice | ___ Yes ___ No | Swollen Feet or Ankles | ___ Yes ___ No |
| Chemical Dependency | ___ Yes ___ No | Jaw Pain | ___ Yes ___ No | Swollen Neck Glands | ___ Yes ___ No |
| Chemotherapy | ___ Yes ___ No | Kidney Disease | ___ Yes ___ No | Thyroid Problems | ___ Yes ___ No |
| Circulatory Problems | ___ Yes ___ No | Liver Disease | ___ Yes ___ No | Tonsillitis | ___ Yes ___ No |
| Congenital Heart Lesions | ___ Yes ___ No | Low Blood Pressure | ___ Yes ___ No | Tuberculosis | ___ Yes ___ No |
| Cortisone Treatments | ___ Yes ___ No | Mitral Valve Prolapse | ___ Yes ___ No | Tumor or growth on
head or neck | ___ Yes ___ No |
| Cough, persistent or bloody | ___ Yes ___ No | Nervous Problems | ___ Yes ___ No | Ulcer | ___ Yes ___ No |
| Diabetes | ___ Yes ___ No | Pacemaker | ___ Yes ___ No | Venereal Disease | ___ Yes ___ No |
| Emphysema | ___ Yes ___ No | Psychiatric Care | ___ Yes ___ No | Weight Loss, unexplained | ___ Yes ___ No |
| | | Radiation Treatment | ___ Yes ___ No | | |

Women only: 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 _____

3. Allergies

- | | |
|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (Sleeping Pills) | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Latex | _____ |

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: _____

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 to my medical and/or dental status.**

Signature of Patient, Parent, Guardian or Personal Representative

Date