JEFFREY K. MIYAZAWA D.D.S.

"Where lifetime smiles are created"

Patient Information (Confidential)

Name_____ Birth Date_____/_____/_____

Nickname_____ ☐Child☐Single☐ Married

Address_____City_____ State____ Zip_____

Social Security # (for Insurance use)_____-_____-_____Phone(H)_____Cell_____

Email Address_____

Is it okay for us to send you Emails ☐Yes ☐ No ***or*** Text Messages? ☐Yes ☐ No (Confirming your appointment)

Patient's Employer_____Work Phone _____

Business Address_____City_____ State_____Zip_____

Is it okay for us to contact you at work? ☐Yes ☐ No

Spouse/Parent/Guardian Name_____Employer_____

Social Security # (for Insurance use)_____-_____-_____ Birth Date_____/_____/_____

Person to contact in case of emergency_____Relation_____

Home Phone_____ Cell/Work/Other_____

Whom may we thank for referring you? _____

- Yellow Pages
- Mid-week Ad
- Yelp/ Google +
- I workout at 24Hour Fitness / Passed by the office
- Other _____

Insurance Information

We kindly ask that you provide the front office with a valid I.D. and Dental Insurance card so that we may verify benefits and assist you in submitting dental claims. Thank you.

Consent for Treatment:

I hereby grant permission to the attending doctor(s) and staff member(s) to perform all procedures and diagnostic tests that they deem necessary for my dental treatment and oral care. Techniques may include, but are not limited to, the use of radiographs, administration of anesthetics, medicine, and oral surgery. All services that are rendered will be paid by me, my parent/guardian, patient's insurance coverage, or combination thereof.

Our mission is to deliver the finest dental care available today. Fine dentistry is truly an investment, and our goal is to help you make this investment possible. Financial considerations should not be an obstacle to obtaining the health care you deserve.

Signature_____ Date_____

Health Questionnaire

Patient's Name: _____

Do you have or have you had any of the following? ☑ (Please check all that apply)

☐ None	☐ Glaucoma	☐ Pacemaker
☐ AIDS/ HIV complex	☐ Hay Fever	☐ Persistent Cough
☐ Anemia	☐ Head Injuries	☐ Radiation Treatment
☐ Artificial Heart Valves	☐ Heart Ailments or Attack	☐ Respiratory Problems
☐ Artificial Joints	☐ Heart Murmur	☐ Rheumatic Fever
☐ Asthma	☐ Hemophilia	☐ Stomach Problems
☐ Blood Disease	☐ Hepatitis: Type _____	☐ Stroke
☐ Cancer	☐ High Blood Pressure	☐ Thyroid Disease
☐ Diabetes	☐ Kidney Disease	☐ Tuberculosis
☐ Dizziness or Fainting	☐ Liver Disease	☐ Tumors or Growths
☐ Epilepsy	☐ Mitral Valve Prolapse	☐ Ulcers
☐ Excessive Bleeding	☐ Nervous Disorders	☐ Venereal Disease

Drug Allergies ☑ (Please check all that apply)

☐ None	☐ Aspirin	☐ Penicillin
☐ Sulfa Drugs	☐ Codeine	☐ Local Anesthetics
☐ Barbiturates (sleeping pills)	☐ Latex	☐ Other _____

Other Information ☑ (Please check all <u>that apply</u>)

☐ Smoker- How often or how many pack(s) a day? _____

Do you floss? ☐Yes ☐ No If *yes*, How often? _____

Do you have any disease, condition, or problem not listed that you think we should be aware of? ☐ No

_____

_____

Please list medications you are *currently* taking: ☐ None

_____

_____

Have you ever had any serious illness or operation? ☐ No If *yes*, please describe:

_____

_____

Do you have any medical condition that requires pre-medication for your dental appointment? ☐Yes ☐ No

(Women) Are you pregnant? ☐Yes ☐ No If *yes*, how many months? _____Months/Weeks

Signature_____ Date_____