

**PATIENT INFORMATION**

Confidential

Name: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 I prefer to be called: \_\_\_\_\_ Birthdate: \_\_\_\_\_  Male  Female  
 Check appropriate box  Single  Married  Divorced  Widowed  Separated  Minor  
 If patient is a minor, give name of parent or legal guardian \_\_\_\_\_ Relationship: \_\_\_\_\_  
 If patient is a student, name of school/college: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
 Home #: \_\_\_\_\_ Cell/Other #: \_\_\_\_\_  
 Work #: \_\_\_\_\_  
 When & where are the best times to reach you ? \_\_\_\_\_  
 Whom may we Thank for referring you? \_\_\_\_\_  
 Other family members seen by us:  No  Don't Know  Yes Name: \_\_\_\_\_  
 In the event of an emergency, is there someone who does not live with you that we could contact?  
 Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
 Work #: \_\_\_\_\_ Home #: \_\_\_\_\_  
 Previous/Present Dentist: \_\_\_\_\_  
 Last Visit Date: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_

**EMPLOYER AND INSURANCE INFORMATION**

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Work phone #: \_\_\_\_\_ Ext: \_\_\_\_\_  
 Insurance Co.: \_\_\_\_\_ Group No.: \_\_\_\_\_  
 Coverage  Family  Self and Dependents  Self Only  
 How much is your Annual Deductible? \_\_\_\_\_ Maximum Annual Benefit? \_\_\_\_\_

**SPOUSE INFORMATION**

His/Her Name: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Work phone #: \_\_\_\_\_ Ext: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Insurance Co.: \_\_\_\_\_ Group No.: \_\_\_\_\_  
 Coverage  Family  Self and Dependents  Self Only  
 Annual Deductible: \_\_\_\_\_ Maximum Annual Benefit: \_\_\_\_\_

The above information is correct to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify this office of any changes to the above information

Copies of this office's Notice of Privacy Practices and the Dental Materials Fact Sheet dated May 2004 are available upon request.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## **DENTAL HEALTH HISTORY**

**PATIENT'S NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Reason for visit: \_\_\_\_\_

How long since your last dental visit? \_\_\_\_\_ last cleaning: \_\_\_\_\_ Last full mouth x-rays: \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss your teeth? \_\_\_\_\_

Do you use tobacco in any form? [Y] [N] If yes, which kind and how much? \_\_\_\_\_

Do you use alcoholic beverages (more than two drinks per day)? \_\_\_\_\_

On a scale of 1-10, 10 being the best, where would you rate your smile?

On a scale of 1-10, 10 being the best, where would you rate your oral health?

On a scale of 1-10, 10 being the best, where would you rate the importance of your oral health?

Is keeping your teeth important to you? [Y] [N]

Have you experienced any of the following problems: Circle all that apply

Bleeding gums	Sensitivity to Hot & Cold	Bad Breath or sour taste in mouth
Burning sensations in mouth	Migraines	Food catching between teeth
Soreness in jaw	Grinding of Teeth	Difficulty opening wide
Clicking or popping in jaw	Stiff neck muscles	Dry mouth
Snoring/Sleep Apnea	Pain/soreness around ears, eyes, face	None of the above

Does having dental treatment make you afraid or nervous? [Y] [N] If yes, what specific things bother you?

\_\_\_\_\_

If you could change anything about your smile which of the following would you want?

Whiter [Y] [N],	Straighter [Y] [N],	Close space or spaces [Y] [N],
Replace missing teeth [Y] [N]	Less Gum showing [Y] [N],	Replace old crowns [Y] [N]
Excess showing of Teeth [Y] [N]	Replace old plastic filling(s) [Y] [N]	Remove Stains/Spots on teeth [Y] [N]
Reshape/resize my teeth [Y] [N]	Replace chipped teeth [Y] [N]	Remove silver fillings [Y] [N]

Fill in this question for us please: Where do you see yourself and your overall oral health and/or your smile in the next 5 to 10 years? \_\_\_\_\_

Please circle the following which are important to you when making your dental health decision.

Health	Fear or Anxiety	Relationship with Dental Team
Comfort	Technology	What insurance covers
Convenience	Appearance	Finances
Time	Quality of care	Detailed treatment explanations

**MEDICAL HISTORY**

**Confidential**

**Patient Name:** First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Date of Birth \_\_\_\_\_

The practice of dentistry includes treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my physician.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Personal physician: \_\_\_\_\_ Physician's phone #: \_\_\_\_\_

Your current physical health is  Good  Fair  Poor

Are you taking any prescription / non-prescription / over-the-counter drugs or herbs?  No  Yes

Please list each one: \_\_\_\_\_

Are you being treated by a physician now?  No  Yes

If YES, explain \_\_\_\_\_

Has there been a change in your health within the last year?  No  Yes

If YES, explain \_\_\_\_\_

Have you gone to the hospital or emergency room or had a serious illness in the last three years?  No  Yes

If YES, explain \_\_\_\_\_

**For Women:** Are you taking birth control pills?  No  Yes

Are you pregnant?  No  Yes Week # \_\_\_\_\_

Are you nursing?  No  Yes

**CIRCLE ANY OF THE FOLLOWING YOU HAVE EXPERIENCED**

- |                          |                               |                                |
|--------------------------|-------------------------------|--------------------------------|
| Abnormal Bleeding        | Difficulty Swallowing         | Joint Pain or Stiffness        |
| Anxiety                  | Difficulty Urinating          | Night Sweats                   |
| Blood in Stools          | Dizziness                     | Persistent Cough               |
| Blood in Urine           | Excessive Thirst              | Recent Significant Weight Loss |
| Blurred Vision           | Fainting Spells / Nervousness | Ringing in Ears                |
| Bruise Easily            | Fever                         | Shortness of Breath            |
| Chest Pain (Angina)      | Frequent Urination            | Sinus Problems                 |
| Coughing Up Blood        | Frequent Vomiting             | Swollen Ankles                 |
| Depression               | Headaches                     | Other _____                    |
| Diarrhea or constipation | Jaundice                      | None of the Above              |

**CIRCLE ANY OF THE FOLLOWING YOU HAVE OR HAD**

- |                                     |                                 |                             |
|-------------------------------------|---------------------------------|-----------------------------|
| Anemia / Blood Disorders            | Family History of Heart Disease | Radiation                   |
| Arthritis / Inflammatory Disease    | Glaucoma                        | Recurrent Illnesses         |
| Artificial Heart Valve / Transplant | Hardening of Arteries           | Respiratory / Lung Disease  |
| Artificial Joint (Hip, Knee, etc.)  | Heart Attack                    | Rheumatic Fever             |
| Asthma                              | Heart Defects                   | Shingles / Herpes Virus     |
| Cancer / Tumor                      | Heart Murmurs                   | Skin Disease                |
| Cardiovascular Disease              | Heart Stent / By-Pass Surgery   | Slow-Healing Mouth Sores    |
| Chemotherapy                        | Hepatitis, any form             | Sore / Enlarged Lymph Nodes |
| Congenital Heart Disease            | High / Low Blood Pressure       | Stomach Problems or Ulcers  |
| Cosmetic Surgery                    | HIV Infection / AIDS or ARC     | Stroke                      |
| Diabetes                            | Hospitalization                 | Surgeries                   |
| Drug or Alcohol Abuse               | Kidney Problems                 | Thyroid Disease             |
| Eating Disorder                     | Liver Disease / Jaundice        | Tuberculosis                |
| Emphysema                           | Osteoporosis                    | Venereal Disease            |
| Epilepsy / Seizures                 | Previous Bacterial Endocarditis | Other _____                 |
| Family History of Diabetes          | Psychiatric Treatment           | None of the Above           |



**Michele Yamada, D.D.S., Inc.**  
**1802 Cable St.**  
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**FINANCIAL ARRANGEMENT AGREEMENT**

Thank you for selecting our office for your dental care. WE are committed to the success of your treatment. Please understand that payment at the time of your treatment is considered a part of your commitment to our office.

In order to be impartial to everyone, **PAYMENT IS REQUIRED AT THE TIME OF TREATMENT.** We ask that you read and sign along with us, this statement prior to any treatment. We accept cash, check, debit cards as well as ALL MAJOR CREDIT CARDS. For extensive treatment plans, we offer extended payment plans with our Care Credit or Citi Health Card options at either little or NO interest with prior credit approval.

**REGARDING INSURANCE**

We will gladly file all dental claims for the given treatment but we are not party to any insurance programs or contracts. We are a NON-RESTRICTIVE provider. The balance is **YOUR** responsibility whether your insurance carrier pays for your treatment or not. It is **YOUR** responsibility, that after **45** days without payment from your insurance carrier, the **TOTAL** balance due on the account is owed by you.

**MISSED APPOINTMENTS**

Your appointment time is reserved for you. A broken appointment affects everyone, as that allotted time could have been given to someone else in need. You will be responsible for a cancellation fee if you are unable to give **48 business hours** notice of cancellation and a per hour fee for cancellations with less than 24 hours notice per our business hours. We realize that emergencies can occur. Should an unforeseen situation prevent you from keeping a pre-arranged appointment, please contact our office to avoid the possibility of a misunderstanding.

**FINANCE CHARGES**

I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that any unpaid balance after 30 days is charged a yearly finance charge of 18% annually, which is equal to 1.5% of my outstanding balance per month. **I understand that if my account reaches collection status (90 days) and I make no effort to pay off my account, my account will be assigned to a collection attorney or agency. If Dr. Yamada must take additional steps to collect my account, I will pay ALL cost of collection, including court cost and attorney's fees incurred by Dr. Yamada.**

Thank you for taking the time to read and understand our financial agreement. Our practice is committed to providing the best treatment for our patients. Please let us know if you have any questions. Our financial coordinator would be glad to review the agreement with you at any time.

Financial Coordinator: \_\_\_\_\_ Date \_\_\_\_\_

Patient Name (Printed) : \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_