



**Smile Design**  
**Robert Y. Takano, D.D.S.**  
**801 24<sup>th</sup> Avenue NW**

**Patient Information**

Patient Name: \_\_\_\_\_ Date \_\_\_\_\_  
Last First MI (Preferred Name)

E-Mail: \_\_\_\_\_ Gender: \_\_\_\_\_ Family Status: \_\_\_\_\_

Social Security \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ (Mobile): \_\_\_\_\_

Preferred appointment times:  Morning  Afternoon  Any Time  M  T  W  T  F

Address: \_\_\_\_\_  
Street Apartment #

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Health Information**

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

**Have you ever had any of the following? Please check those that apply:**

1. Do you think that your teeth are affecting your general health? .....  Yes  No
2. Are you dissatisfied with the appearance of your teeth? .....  Yes  No
3. Are you interested in having braces? .....  Yes  No
4. Are you worried about receiving dental treatment or have you ever fainted? .....  Yes  No
5. Do you have difficulty chewing your food or opening your mouth wide? .....  Yes  No
6. Do you have sensitive teeth, bleeding gums or sore gums? .....  Yes  No
7. Do you ever have canker sores, cold sores or a sore mouth? .....  Yes  No
8. Have you ever had an injury to your face or jaws? .....  Yes  No
9. Are you currently taking any prescription medications? (Please list) .....  Yes  No
  
10. Have you ever experienced an unusual reaction to a dental anesthetic? .....  Yes  No
11. Have you ever experienced an unusual reaction to any of the following drugs? (Please circle)  
 Aspirin, Penicillin, Iodine, Sulfa drugs, other medications
12. Have you ever been treated for alcohol or drug dependency or do you use tobacco? .....  Yes  No
13. Have you been examined by a physician within the last year? .....  Yes  No
14. Is a physician treating you at the present time? .....  Yes  No
15. Have you ever been seriously ill, hospitalized or had surgery? .....  Yes  No
16. Have you ever had a blood transfusion? .....  Yes  No
17. Have you ever radium or cobalt treatments? .....  Yes  No
18. Have you ever been treated for a growth, tumor, cancer, malignancy or any other  
 Similar condition? .....  Yes  No
19. Do you have any reason to believe that you have been exposed to HIV/AIDS? .....  Yes  No
20. Have you ever had an artificial joint, pin, plate or other device surgically implanted? .....  Yes  No
21. Have you ever had any of the following diseases? (Please circle) Rheumatic Fever, Kidney Disease,  
 Hepatitis, Liver Disease, Tuberculosis, Venereal Disease, Heart Attack, Stroke, Bleeding Disorder,  
 Stomach Ulcers, Epilepsy, Diabetes, High Blood Pressure, Mononucleosis, Depression/Anxiety,  
 Eating Disorder, Intestinal Disorder, or any other disease.
22. Do you have a pacemaker? .....  Yes  No
23. Have you ever had any heart valve disorders? .....  Yes  No
24. Have you ever been told by a physician that you have a heart murmur? .....  Yes  No
25. Has there been any change in your general health recently? .....  Yes  No
26. Do you bleed for a long time when cut? .....  Yes  No
27. Do you have frequent colds, sore throats or nosebleeds? .....  Yes  No
28. Has your appetite changed or have you had an unexplainable change in weight? .....  Yes  No
29. Do you have excessive thirst or urinate with unusual frequency? .....  Yes  No
30. Do you have asthma, hay fever, hives, itchiness, skin rash or respiratory allergies? .....  Yes  No
31. Do you have a chronic cough or do you ever cough up blood? .....  Yes  No
32. Do you ever have chest pain, difficulty climbing two flights of stairs, or swelling of the ankles? .....  Yes  No
33. Females – Are you pregnant? .....  Yes  No

**Referral Information**

Whom may we thank for referring you to our practice?  Another patient, friend  another patient, relative

Dental Office  Yellow Pages  Insurance  School  Work  Other \_\_\_\_\_

Name of person or office referring you to our practice \_\_\_\_\_

## Spouse or Responsible Party Information

The following is for  the patient's spouse  the person responsible for payment

Name: \_\_\_\_\_

Male  Female  Married  Single  Child  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Address: \_\_\_\_\_

Street

Apartment #

City

State

Zip Code

## Employment Information

The following is for  the patient  the person responsible for payment

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City, State Zip Code

Phone

## Insurance Information

### Primary

Name of Insured: \_\_\_\_\_ is insured a patient?  Yes  No

Last

First

MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

Street

City

State

Zip Code

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

### Secondary

Name of Insured: \_\_\_\_\_ is insured a patient?  Yes  No

Last

First

MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

Street

City

State

Zip Code

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

## Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

I understand that if a local anesthetic is required, there may be temporary and sometimes permanent loss of sensation and muscle function following injections.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

**I have read the above conditions of treatment and payment, and agree to their content. I have received and read HIPPA Guidelines**

**I have received a copy of the Dental Materials Fact Sheet as required by law.**

\_\_\_\_\_  
Signature of patient, parent or guardian

Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of guarantor of payment/responsible party

Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_