Welcome to our dental office. We appreciate the trust you have placed in us, and we will strive to provide the high quality of dental care that you expect.

The focus of our practice is health-centered, preventative dentistry. We enjoy helping people actively participate in their own health care and control the causes of dental disease. Further, we emphasize aesthetic, adult restorative treatment designed for long-term beauty, comfort, function and low maintenance.

Our staff members are devoted to making your appointments as pleasant and enjoyable as possible. We take great pride in our ability to provide you with optimal dental care designed for your unique needs and desires.

The first step toward complete oral health is thorough examination and diagnosis. We want our patients to make informed choices by fully understanding any problems. The doctors will review your dental needs with you at this appointment or at a second appointment to provide treatment consultation.

We look forward to meeting you! Your first appointment will be approximately 75 minutes. In order that we may respond to your unique needs and concerns, please complete the enclosed medical history and dental questionnaire and bring them to your appointment. Feel free to ask questions of our staff. We are all here to help you.

Sincerely,

Dr. Alan Miyamoto
Dr. Michael Miyamoto
Registration Form

Please fill out accurately and completely. The confidential information requested is important for your treatment and insurance claim. If there is anything else we need to know, please tell us.

PATIENT INFORMATION

Patient Name: _______________________________ Gender: ______ Date of Birth: ________________

Home Address: __________________________________________

Mailing Address: __________________________________________

E-mail Address: __________________________________________

Phone: Home ___________________ Cell ___________________ Work ___________________

Employed By: ___________________________________________ Occupation: __________________________

Social Security Number: ___________________________ (need only if used for insurance ID)

Best appointment times: __________________________________

Dental Insurance and #: ________________________________ Subscriber Name: _______________________

Secondary Dental Insurance and #: ______________________ Subscriber Name: _______________________

Relative/Friend NOT living with you: __________________________

Phone: __________________________ Relationship: __________________________

How were you referred to our office? __________________________________

SPOUSE INFORMATION

Spouse Name: _______________________________ Date of Birth: ________________

Employed By: _______________________________ Occupation: __________________________

Phone: Cell _______________________________ Work __________________________

Social Security Number: __________________________
Medical Information

Please check any of the following that apply and list any medication that you are taking:

- Migraine headaches: ____________________________________________________________
- Mitral valve prolapse: __________________________________________________________
- Pacemaker/defibrillator: _________________________________________________________
- Frequent chest pain: ____________________________________________________________
- Heart trouble/attack (date _____): _______________________________________________
- Heart surgery: (date _____): ____________________________________________________
- Heart murmur: _________________________________________________________________
- Stroke: (date _____): __________________________________________________________
- Cholesterol: _________________________________________________________________
- High blood pressure: __________________________________________________________
- Low blood pressure: __________________________________________________________
- Thyroid: ___________________________________________________________________
- Anemia: ___________________________________________________________________
- Diabetes: ___________________________________________________________________
- Kidney disease: __________________________________________________________________
- Liver disease: __________________________________________________________________
- Hepatitis: (type) A B C __________________________________________________________________
- Tuberculosis: (date _____): __________________________________________________________________
- Asthma: ___________________________________________________________________
- Abnormal bleeding: __________________________________________________________________
- Osteoporosis: __Fosamax__ __Actonel__ __________________________________________________________________
- Epilepsy: ___________________________________________________________________
- Joint replacement: (date _____ area ____________): __________________________________________________________________
- Cancer: (date _____ type _____): __________________________________________________________________
- Lupus: ___________________________________________________________________
- Drug addiction: __________________________________________________________________
- HIV/AIDS: ___________________________________________________________________
- Pregnant/nursing: __________________________________________________________________
- Birth control pills/patch: __________________________________________________________________
- Tobacco: ___________________________________________________________________
- Antibiotics for dental work: __________________________________________________________________
- Blood thinners: __________________________________________________________________

Other physical conditions:
- Allergies: (please circle) penicillin aspirin local anesthesia latex codeine (or other narcotics) metal/costume jewelry other __________________________________________________________________
- Other physical conditions: __________________________________________________________________

Please list other medications taking: ____________________________________________________________
FINANCIAL INFORMATION

Fees are due and payable at the time of service. For major treatment, we require 50% down before starting the procedure and the balance will be collected upon the completion of the treatment. We will file your insurance claims with the information you provide us. Unless you have HDS, a payment is expected in full. Please be aware that interest will be charged on delinquent balances, and if your account must be turned over to a collection agency, collection costs will be added.

I hereby grant permission to the doctors and staff of this office to perform such procedures, or consult with specialists as necessary and work with them in caring for my oral health. I will try to keep all my appointments or call to reschedule at least 48 hours in advance to avoid the cancellation charge. I also agree to the financial terms stated above.

Signed By:________________________________ Date:____________________

Signed By:________________________________ Date:____________________

Signed By:________________________________ Date:____________________

Signed By:________________________________ Date:____________________

Signed By:________________________________ Date:____________________

Signed By:________________________________ Date:____________________

Signed By:________________________________ Date:____________________

Signed By:________________________________ Date:____________________
Patient Questionnaire

Name ___________________________________________ Date __________________________

Our practice is committed to providing each of our patients with individualized care consistent with their specific needs, wants, and values. By answering the following questions candidly, you will help us to better understand your dental concerns and expectations. Your answers are for our records only and will remain confidential.

1. Does dental treatment make you nervous? □ No □ Slightly □ Moderately □ Extremely
2. Have you ever had any serious trouble associated with previous dentistry? □ Yes □ No
3. How often do you use the following?
   Toothbrush (manual or electric) __________________________
   Dental floss __________________________
   Other oral hygiene device __________________________

4. Do you have or have you ever had any of the following?
   Orthodontic treatment (braces)? □ Yes □ No Loose teeth? □ Yes □ No
   Clicking/popping jaw? □ Yes □ No Teeth sensitive to hot, cold, sweet? □ Yes □ No
   Difficulty opening or closing jaw? □ Yes □ No Teeth sensitive to chewing? □ Yes □ No
   Clenching or grinding? □ Yes □ No Bleeding or sore gums? □ Yes □ No
   Shift or change in bite? □ Yes □ No Unpleasant taste or bad breath? □ Yes □ No

5. The following best describes my attitude toward dental health:
   □ I have always done what was recommended for my dental health.
   □ I have not always done what dentists have recommended to me.
   □ I rarely go to the dentist, not much interest in dental work.

6. Should I need treatment, my desires would be best described as:
   □ wanting the best restoration possible that will be the most conservative and give the longest life.
   □ wanting the least expensive restoration that will get me by for now.

7. Do you like the color of your teeth? □ Yes □ No
   If NO, please describe __________________________________________

8. Do you consider your existing fillings or dental work as unattractive? □ Yes □ No
   If YES, please describe __________________________________________

9. What would you like to change the most in the appearance of your teeth, your smile?
   __________________________________________

10. What are some questions about dentistry and your oral health that you have never had adequately answered?
    __________________________________________