Charles and Morishita, A.D.C.
Patient Information and Medical History

For Office Use Only
ID:

Patient's Name:_____ Today's Date: _____/_____/_____

Street Address: _____ Date of Last Visit: _____/_____/_____

City, State, Zip: _____ Date of Med History: _____/_____/_____

Home Phone:(_____)_____ Work Phone:(_____)_____ Birthdate: _____/_____/_____

Email:_____ Marital Status: _____ Social Security No.: _____ - ____ - _____

Employer:_____ Employer's Street Address:_____

City, State, Zip:_____

Spouse's Name:_____ Day Time Phone:(_____)_____

If patient is a minor: Parent's/Guardian's Name: _____ School:_____

Your General Dentist's Name: _____ Phone: (_____)_____

Whom may we thank for referring you to our office (if other than your general dentist): _____

Name of nearest relative not living with you: _____

Street Address:_____ Telephone: (_____)_____

City, State, Zip:_____

Primary Insured Dental Insurance Information *(Please complete all pertinent information so that we may serve you better.)*

Name:_____ Birthdate:_____/_____/_____ Social Security No.: _____ - ____ - _____

Insurance Company:_____ Group Number: _____

Street Address:_____ Telephone: (_____)_____

City, State, Zip:_____

Insured's Employer: _____

Employer's Street Address:_____ Telephone: (_____)_____

City, State, Zip:_____

Secondary Insured Dental Insurance Information ☐ N/A (no secondary dental insurance coverage)

Name:_____ Birthdate:_____/_____/_____ Social Security No.: _____ - ____ - _____

Insurance Company:_____ Group Number: _____

Street Address:_____ Telephone: (_____)_____

City, State, Zip:_____

Insured's Employer: _____

Employer's Street Address:_____ Telephone: (_____)_____

City, State, Zip:_____

Insurance Authorization: Signature on File *Please initial as appropriate:*

_____ I understand that I am responsible for my bill, and any finance charges that may accumulate after 90 days.

_____ I authorize payment directly to my doctor.

_____ I authorize release of information to all of my insurance companies.

_____ I permit a copy of this authorization to be used in place of the original.

Please continue to the other side.

Medical History

Y N

☐ ☐ Do you smoke or use tobacco?

Height: _____ Weight: _____

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BP: _____/_____ Heart Rate: _____

Females Only: ☐ N/A (male)

Y N

☐ ☐ Are you taking birth control pills?

☐ ☐ Are you pregnant? If yes, no. of weeks:_____

☐ ☐ Are you nursing?

Y	N	Conditions
☐	☐	PRE-MED
☐	☐	Heart Problems
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Heart Murmur
☐	☐	Bacterial Endocarditis
☐	☐	Congenital Heart Defect
☐	☐	Mitral Valve Prolapse
☐	☐	Artificial Heart Valve
☐	☐	Abnormal Heart Rhythm
☐	☐	Heart Pacemaker
☐	☐	High Blood Pressure
☐	☐	Chest Pains
☐	☐	Artificial Joint
☐	☐	Surgical Implants
☐	☐	Organ Transplant
☐	☐	Surgery
☐	☐	Arthritis/Rheumatism
☐	☐	Kidney Problems
☐	☐	Prolonged Bleeding
☐	☐	Bisphosphonates (Fosamax)
☐	☐	Cortisone Medication

Y	N	Conditions
☐	☐	Anemia
☐	☐	Diabetes
☐	☐	Thyroid Problems
☐	☐	Emphysema
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Asthma
☐	☐	Hay Fever
☐	☐	Sinus Problems
☐	☐	Cancer
☐	☐	Radiation Therapy
☐	☐	Chemotherapy
☐	☐	Seizures
☐	☐	Stroke/Neurological
☐	☐	Fainting Spells
☐	☐	Alcohol/Drug Abuse
☐	☐	Autoimmune Disorder
☐	☐	Blood Disorders
☐	☐	Sickle Cell Disease
☐	☐	Hemophilia
☐	☐	Blood Transfusion
☐	☐	Hepatitis A, B, C

Y	N	Conditions
☐	☐	Yellow Jaundice
☐	☐	Liver Disease
☐	☐	Venereal Disease
☐	☐	Herpes
☐	☐	HIV+ AIDS
☐	☐	Psychological

Y	N	Allergies to:
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline
☐	☐	Other, list below:

_____

_____

_____

_____

Y N

☐ ☐ Is there any disease, condition, or problem that you think this office should know about that is not covered above?

If yes, please describe briefly: _____

_____

_____

Your Physician's Name: _____ Phone: (_____)_____

Please list current medications:_____

_____

Patient's Signature:_____ Today's Date: _____/_____/_____

(If under 18, Parent or Guardian Signature Required)