CHARLES & MORISHITA, A.D.C

Practice Limited to Periodontics and Implant Surgery

Medical History

Patient Name:

Medical Alert:

Have you been under the care of a medical doctor during the past two years? YES NO

If yes, for what? _____

Physician's Name: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

Have you taken any medication or drugs during the past two years? YES NO

Are you taking any medication, drugs, or pills now? YES NO

If yes, please list: _____

Are you allergic to or had an adverse reaction to:

Penicillin YES NO	Sulfa drugs YES NO	Aspirin YES NO
Local Anesthetic YES NO	Erythromycin YES NO	Motrin YES NO
Other_____	Codeine YES NO	

Have you been a patient in the hospital during the past five years? YES NO

Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item.

Heart (Surgery, Disease, Attack)	YES NO	Ulcers	YES NO	Hepatitis A (Infectious)	YES NO
Heart Murmur	YES NO	Diabetes	YES NO	Hepatitis B (Serum)	YES NO
Congenital Heart Disease	YES NO	Thyroid Problems	YES NO	Hepatitis C	YES NO
Mitral Valve Prolapse	YES NO	Glaucoma	YES NO	Venereal Disease	YES NO
Artificial Heart Valve	YES NO	Phen Fen	YES NO	A.I.D.S.	YES NO
Rheumatic Fever	YES NO	Emphysema	YES NO	H.I.V. Positive	YES NO
Heart Pacemaker	YES NO	Chronic Cough	YES NO	Cold Sores/ Fever Blisters	YES NO
Artificial Joint (Hip, Knee, etc)	YES NO	Tuberculosis	YES NO	Herpes	YES NO
High Blood Pressure	YES NO	Asthma	YES NO	Blood Transfusion	YES NO
Chest Pain	YES NO	Hay Fever	YES NO	Hemophilia	YES NO
Cortisone Medicine	YES NO	Latex Sensitivity	YES NO	Sickle Cell Disease	YES NO
Swollen Ankles	YES NO	Allergies or Hives	YES NO	Bruise Easily	YES NO
Stroke	YES NO	Sinus Trouble	YES NO	Yellow Jaundice	YES NO
Diet (Special/Restricted)	YES NO	Radiation Therapy	YES NO	Neurological Disorders	YES NO
Arthritis/Rheumatism	YES NO	Chemotherapy	YES NO	Epilepsy or Seizures	YES NO
Kidney Trouble	YES NO	Tumors	YES NO	Fainting or Dizzy Spells	YES NO
Prolonged Bleeding	YES NO	Excessive Bleeding	YES NO	Nervous/Anxious	YES NO
Biphosphonates (Fosamax)	YES NO	Liver Disease	YES NO	Psychiatric/Psychological Care	YES NO

Do you have or have you had any disease, condition, or problem not listed? YES NO

If yes, please list: _____

Women, are you: Pregnant: YES NO Nursing: YES NO Taking Birth Control Pills: YES NO

Menopausal YES NO Post-menopausal: YES NO

Have you lost or gained more than 10 pounds in the past year? YES NO

Do you use more than two pillows to sleep? YES NO

I understand the above information is necessary to provide me with dental care. I have answered all questions to the best of my knowledge. Should further information be necessary, I give permission to ask the respective health care provider or agency, who may release such information. I will inform the doctor of any change in my health or medication.

Patient/Guardian Signature: _____ Date: _____

History Update:

I have reviewed my medical history. It remains unchanged. YES NO

Note the following changes:

Signature: Date:

I have reviewed my medical history. It remains unchanged. YES NO

Note the following changes:

Signature: Date:

Allan H. Charles, D.D.S. Wilson S. Morishita, D.D.S.

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Dental History

Patient Name:

Welcome! So that we may provide you with the best possible care,
please complete both sides of this medical/dental history form.
All information will be completely confidential.

What is the reason for your visit? _____

_____

Who referred you to our practice? _____

Referring Dentist: _____ Telephone _____

Address: _____ City: _____ State: _____ Zip: _____

Date of last dental cleaning: _____ How often do you have cleanings? _____

How often do you brush your teeth? _____ How often do you floss? _____

Do you use other dental cleaning aids? (toothpicks, automatic toothbrush) _____

Are you having any dental problems now? **YES** **NO**

If so, please describe: _____

Are your teeth sensitive to:

Hot or cold?	YES	NO
Sweets?	YES	NO
Biting or chewing?	YES	NO
Have you noticed any mouth odors or bad tastes?	YES	NO
Do you frequently get cold sores, blisters or any other oral lesions?	YES	NO

Do your gums bleed or hurt? **YES** **NO**

Have your parents experienced gum disease or tooth loss?	YES	NO
Have you noticed any loose teeth or change in your bite?	YES	NO
Does food tend to become caught in between your teeth?	YES	NO

If yes, where: _____

Do you:

Clench or grind your teeth while awake or asleep?	YES	NO
Bite your lips or cheeks regularly?	YES	NO
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	YES	NO
Mouth breath while awake or asleep?	YES	NO
Have tired jaws, especially in the morning?	YES	NO
Smoke or chew tobacco?	YES	NO

Have you ever had:

Orthodontic treatment?	YES	NO
Oral Surgery?	YES	NO
Periodontal treatment?	YES	NO
Your teeth ground or the bite adjusted?	YES	NO
A bite plate or mouth guard?	YES	NO
A serious injury to the mouth or head?	YES	NO

If so, please describe, including cause: _____

_____

Have you experienced:

Clicking or popping of the jaw?	YES	NO
Pain (joint, ear, side of face)?	YES	NO
Difficulty in opening or closing the mouth?	YES	NO
Difficulty in chewing on either side of the mouth?	YES	NO
Headaches, neckaches, or shoulder aches?	YES	NO
Sore muscles (neck, shoulders)?	YES	NO
Are you satisfied with the appearance of your teeth?	YES	NO
Would you like to keep your teeth all of your life?	YES	NO
Do you feel nervous about having dental treatment?	YES	NO
Have you ever had an upsetting dental experience?	YES	NO

If yes, please describe: _____

_____

Is there anything else about having dental treatment that you would like us to know? **YES** **NO**

If yes, please describe: _____

_____

_____

(Please complete other side)

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Allan H. Charles, D.D.S. Wilson S. Morishita, D.D.S.

Patient Information:

Patient Name: Mr. Miss Mrs. Ms. Dr. _____ (First) _____ (Middle) _____ (Last) Date of Birth: _____

Address: _____ Social Security Number: _____

City: _____ State: _____ Zip: _____

Home Telephone _____ Work Telephone: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Spouse's Name: _____ Day Time Telephone: _____

If patient is a minor, parent's or guardian's name: _____ School: _____

Your general dentist's name: _____ Telephone: _____

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

Name of nearest relative not living with you: _____

Address: _____ Telephone: _____

City: _____ State: _____ Zip: _____

Dental Insurance Information (Please complete all pertinent infomation so that we may serve you better.)

Primary Insured's Name: _____ S S Number: _____ Birth Date: _____

Insurance Company: _____ Group Number: _____

Address: _____ Telephone: _____

City: _____ State: _____ Zip: _____

Insured's Employer: _____ Telephone: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Do you have dual dental insurance coverage? YES NO If yes, complete the following information:

Secondary Insured's Name: _____ S S Number: _____ Birth Date: _____

Insurance Company: _____ Group Number: _____

Address: _____ Telephone: _____

City: _____ State: _____ Zip: _____

Insured's Employer: _____ Telephone: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Insurance Authorization : Signature On File

(Please initial as appropriate)

_____ I understand that I am responsible for my bill.

_____ I authorize payment directly to my doctor.

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

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

Signature: _____ **Date:** _____