PATIENT REGISTRATION FORM

PATIENT INFORMATION

Today's Date:_______________________

Name:____ ___________________
First M.I. Last Nickname

Address: ____ ______________________ _______ ____________
Street City State Zip

Phone: (______)_________________ (_______)__________________ (________)_________________
Home Work Cell

Birthdate: ________________ Social Security #: _________________ E-mail: _____________________________

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

INSURANCE INFORMATION

Primary Carrier:

____ ______________________ ________________________
Insurance Company Group # Insured ID's #

____
Mailing Address for Submitting Claims

_________________________________ _____________ ____________________ __________________________
Name of Insured Birthdate Social Security # Relationship to patient

Secondary Carrier:

____ ______________________ ________________________
Insurance Company Group # Insured ID's #

_________________________________ _____________ ____________________ __________________________
Name of Insured Birthdate Social Security # Relationship to patient

ACCOUNT INFORMATION – (Person financially responsible for account)

Name:____
First M.I. Last

Address: ____ ______________________ _______ ____________
Street City State Zip

Phone: (______)_________________ (_______)__________________ (________)_________________
Home Work Cell

Social Security #: _________________________ Relationship to patient: ________________________________

Occupation: _____________________________ Employer's Name: ______________________________________

Address: ____ ______________________ _______ ____________
Street City State Zip

PATIENT REGISTRATION FORM – page 2

EMERGENCY CONTACT INFORMATION

Name:____ Relationship to patient: ____________________

Address: ______________________________________ ___________________ ______ ___________
Street City State Zip

Phone: (______)________________ (_______)_________________ (________)_________________
Home Work Cell

ADDITIONAL INFORMATION

Whom may we thank for referring you?

☐ One of our valued patients (please provide name of patient) ___________________________________

☐ Our website (www.yoshiokadental.com)

☐ Other: ____

____

CONSENT FOR TREATMENT & PATIENT RESPONSIBILITIES

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by the doctor and myself.
3. I understand and agree that anesthetics, sedatives, and/or other medication may be used. I also understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that the doctor be informed of all medications that are currently being taken.
4. I give consent for the doctor's or designated staff's to use and disclose any oral, written, or electronic health records that are individually identifiable as mine for the purposes of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. If payments are not received by the agreed upon dates, I understand that a late charge may be added to my account.
6. I understand that the office staff reserves the doctor and/or hygienist's time on the schedule for each patient procedure. Thus a 24 hour notice is required to reschedule an appointment. If less than a 24 hour notice is given, a fee may be applied.

____ ________________
Patient Signature Date

____ ________________
Parent/Responsible Party's Signature Relationship to Patient

DONALD S. YOSHIOKA, D.D.S., INC.
STEVEN H. YOSHIOKA, D.D.S.
JULIANNE K. YOSHIOKA-WONG, D.D.S.
1888 Saratoga Avenue, Suite 103
San Jose, CA 95129

AUTHORIZATION FOR SUBMISSION OF CLAIMS AND ASSIGNMENT OF BENEFITS

I authorize the health care provider named above to submit claims for payment for services to the health care service plans or insurance companies, on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

__________________ ______________________________________
Date Name of Patient

____
Signature of Patient, Parent, or Guardian

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize the physician, dentist, or other health care provider named above to release to hospital or health care service plans, insurance companies, self-insurers, or their representatives, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed to review, investigate, or evaluate any claim for benefits.

If my coverage is under a group master agreement held by my employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

I know that I have the right to receive a copy of this authorization, if requested.

__________________ ______________________________________
Date Name of Patient

____
Signature of Patient, Parent, or Guardian

HEALTH HISTORY FORM

MEDICAL ALERT: ___________________________

Today's Date:___________________________

Name:____ Birthdate: _______________________

First M.I. Last

Physician's Name:____ Phone #: _______________________

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1. Are you being treated by a physician now? ☐ No ☐ Yes – please explain: ____
2. Has there been a change in your health within the last year? ☐ No ☐ Yes – please explain: _____________________________
3. Have you been a patient in the hospital or had a serious illness during the past five years? ☐ No ☐ Yes
4. Have you taken any medication or drugs during the past two years? ☐ No ☐ Yes – please list: ___________________________
5. Are you currently taking any medication, drugs, pills, or herbal remedies (including regular dosages of aspirin)?

   ☐ No ☐ Yes – please list: ____
6. Have you ever taken prescription medication for weight loss (diet pills)? ☐ No ☐ Yes

   A. Did you have a medical exam for heart issues? ☐ No ☐ Yes
7. Have you ever taken bone loss prevention drugs (i.e Fosamax, Actonel, Boniva)? ☐ No ☐ Yes
8. Are you aware of having an allergic (or adverse) reaction to any substance (i.e. latex)

   or medication (i.e. penicillin, erythromycin, etc.)? ☐ No ☐ Yes – please explain: ____
9. Have you ever been pre-medicated for dental treatment? ☐ No ☐ Yes
10. Do you smoke or use any type of tobacco products? ☐ No ☐ Yes
11. WOMEN: Are you pregnant or think you could be pregnant? ☐ No ☐ Yes _______months Are you nursing? ☐ No ☐ Yes

    Are you taking birth control pills? ☐ No ☐ Yes
12. Indicate which of the following you have had or presently have:

Heart disease ☐ No ☐ Yes
Heart surgery ☐ No ☐ Yes
Heart attack or stroke ☐ No ☐ Yes
Chest pain ☐ No ☐ Yes
Congenital heart disease ☐ No ☐ Yes
Heart murmur ☐ No ☐ Yes
High/low blood pressure ☐ No ☐ Yes
Mitral valve prolapse ☐ No ☐ Yes
Artificial heart valve/pacemaker ☐ No ☐ Yes
Rheumatic fever ☐ No ☐ Yes
Arthritis/rheumatism ☐ No ☐ Yes
Cortisone medicine ☐ No ☐ Yes
Swollen ankles ☐ No ☐ Yes

Artificial joints (hip,knee,etc.) ☐ No ☐ Yes
Ulcers ☐ No ☐ Yes
Diabetes ☐ No ☐ Yes
Thyroid problems ☐ No ☐ Yes
Glaucoma ☐ No ☐ Yes
Emphysema ☐ No ☐ Yes
Chronic cough ☐ No ☐ Yes
Tuberculosis ☐ No ☐ Yes
Asthma/hay fever/allergy/hives ☐ No ☐ Yes
Sinus trouble ☐ No ☐ Yes
Radiation therapy ☐ No ☐ Yes
Psychiatric/psychological care ☐ No ☐ Yes

Kidney trouble ☐ No ☐ Yes
Chemotherapy ☐ No ☐ Yes
Tumors ☐ No ☐ Yes
Hepatitis A/B/C ☐ No ☐ Yes
AIDS/HIV ☐ No ☐ Yes
Cold sores/fever blisters ☐No ☐Yes
Blood transfusion ☐ No ☐ Yes
Hemophilia ☐ No ☐ Yes
Sickle cell disease ☐ No ☐ Yes
Bruise easily ☐ No ☐ Yes
Liver disease ☐ No ☐ Yes
Neurological disorders ☐ No ☐ Yes
Epilepsy/seizures ☐ No ☐ Yes
Fainting/dizzy spells ☐ No ☐ Yes

Please list any other disease/condition/problem not listed: ____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all of the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider/agency, who may release such information to you. I will notify the doctor of any change in my health and/or medication.

____ ____________________

Patient/Guardian Signature Date

____ ____________________

Dentist's Signature Date

DENTAL HISTORY FORM

MEDICAL ALERT: ______________________________

Today's Date:____________________

Name: _________________________ _____ ____
First M.I. Last

What is the reason for your visit today? ____

Do you have any dental problems?

☐ No ☐ Yes – please describe: ____

Dates:
Last dental visit: ______________ What was done? ____
Last dental cleaning: ______________ Last full mouth x-rays (typically 18-20 x-rays) : ______________
Previous Dentist's Name: _______________________________________ Phone #: (______) ____________

Address: _____________________________________ City & State: _______________ Zip: _______

How often do you have dental examinations?___________ brush your teeth? ___________ floss your teeth?__________

What other dental aids (i.e. water pick, toothpick, proxibrush, etc.) do you use? _________________________

Are any of your teeth sensitive to:

☐ Hot ☐ Cold ☐ Sweets ☐ Biting/chewing

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 – location: ______________ ☐ No

Have any of your parents experienced gum disease or tooth loss?

☐ Yes ☐ No

Have you noticed any loose teeth or change in your bite?

☐ Yes – location: __________________________ ☐ No

Does food tend to get caught in between your teeth?

☐ Yes – location: __________________________ ☐ No

Do you:

☐ Clench or grind your teeth while awake or asleep

☐ Hold foreign objects with your teeth

☐ Mouth breathe while awake or asleep

☐ Have tired jaws, especially in the morning

☐ Snore or have any other sleeping disorders

☐ Smoke/chew tobacco or use other tobacco products

Have you ever had:

☐ Orthodontic treatment

☐ Oral surgery ☐ Mouth guard

☐ Periodontal treatment

☐ A serious injury to the mouth or head?

Please explain: ____________________________

Have you ever experienced:

☐ Clicking or popping of the jaw

☐ Oral surgery ☐ Mouth guard

☐ Pain (jaw, ear, side of the face)

☐ Difficulty in opening or closing your mouth

☐ Difficulty in chewing on either side of your mouth

Are you satisfied with your teeth's appearance?

☐ Yes ☐ No

Do you feel nervous about having dental treatment?

☐ Yes ☐ No

Have you ever had an upsetting dental experience?

☐ Yes ☐ No

Have you ever been told to take a pre-medication prior to dental treatment? ☐ Yes ☐ No

Is there anything else about having dental treatment that you'd like us to know? ☐ Yes - __________________________ ☐ No