**Drs. Nishimine, Nishimine & Tseng**
1406 E Alluvial #101
Fresno, CA 93720

**Phone** 559-229-6557
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## Patient History and Information

NAME: _____ Age:____ Sex:____ Birth Date:_____
LAST FIRST MIDDLE

ADDRESS (HOME): _____ PHONE:_____
STREET CITY STATE/ZIP

ADDRESS (BUS.): _____ PHONE:_____
STREET CITY STATE/ZIP

Employer: _____ Occupation:_____ Social Security No._____

Drivers License No. _____ State and Expiration Date:_____ Marital Status: _____

**Welcome to our practice and thank you for taking the time to fill out this information as it will help us provide an accurate assessment of your needs, and desires for treatment.**

### Insurance Company Information

Name of Company:_____
Address: _____
Phone: _____
Employer: _____
Policy-holder name: _____
Social Security Number of Policy Holder:_____
Date of Birth: _____

### Insurance Company Information (Second)

Name of Company:_____
Address: _____
Phone: _____
Employer: _____
Policy holder name: _____
Social Security Number of Policy holder:_____
Date of Birth: _____

### Our Office Policy

1. Unless emergency care is required, a thorough examination will be made and an estimate of costs will be prepared for your acceptance before treatment is commenced.
2. In the case of minors, we request that either parent approve the dental treatment and fee prior to rendering the services. We adhere strictly to this policy to avoid any misunderstanding.
3. **The fee for emergency care or services requiring only a single office visit is payable at the completion of the appointment.**

### Insurance Claims

To avoid misunderstandings, our policy regarding dental insurance is as follows:

1. Our responsibility is only to you, the patient.
2. Payment for services rendered is the personal responsibility of the patient, **regardless of insurance payment.**
3. We will do everything possible to help you secure a claim by completing your dental forms.

### Acknowledgement and Authority

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever risks, drugs, medicine, performance or operations and conduct of laboratory, x-ray, or other studies that may be used by the attending doctor or qualified designate. Photos may be used for educational or lecture purposes but identity will not be revealed. **I also acknowledge full responsibility for payment of such services and agree to pay for them, in full, at the time of service, unless other written arrangements are made with the financial department.**

Signed _____ Date_____
Patient, Parent or Agent (Must be 18 or older)

**What is the purpose of your visit?**_____

How did you hear about our office:_____ Your general dentist:_____

Previous Dental treatment: Orthodontic ☐ Periodontic (gum)☐ Dental implant ☐
Have you experienced any unfavorable reaction to previous dental treatment? ☐ Yes ☐ No
Do you require antibiotics for Dental Treatment? ☐ Yes ☐ No

**Medical History**

Physician's name: _____ _____Phone: _____

Date of last medical examination: _____ Reason: _____

Name of person to contact in case of emergency: _____ Phone: _____

Have you been in the hospital in the past 5 years? ☐ Yes ☐ No Reason:_____

Have you had any serious illnesses or operations? ☐ Yes ☐ No Reason:_____

Have you ever taken diet drugs Fen-Phen or Redux? ☐ Yes ☐ No When:_____

Do you take drugs for osteoporosis or blood thinners (like aspirin)? ☐ Yes ☐ No

Are you using any recreational drugs or tobacco? ☐ Yes ☐ No

(For women) Are you pregnant? ☐ Yes ☐ No Months:_____

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**Do you have now or have you ever had any of the following:**

| | |
|---|---|
| Heart disease, pacemaker, irregular heartbeat, or endocarditis | ☐ Yes ☐ No |
| Shortness of breath with limited activity or when lying down | ☐ Yes ☐ No |
| Chest pain or angina pectoris or heart attack | ☐ Yes ☐ No |
| Rheumatic fever or rheumatic heart disease | ☐ Yes ☐ No |
| Heart murmur, mitral valve prolapse, prosthetic or artificial valve | ☐ Yes ☐ No |
| Stroke, severe headaches, numbness, or tingling sensations | ☐ Yes ☐ No |
| High blood pressure or low blood pressure | ☐ Yes ☐ No |
| Fainting spells, convulsions or epilepsy | ☐ Yes ☐ No |
| Psychiatric Treatment | ☐ Yes ☐ No |
| Lung Problems (T.B., Asthma, Emphysema, or other breathing problems) | ☐ Yes ☐ No |
| Liver or kidney Disease | ☐ Yes ☐ No |
| Prolonged bleeding or blood disorder | ☐ Yes ☐ No |
| Diabetes: How often do you check? ___ times/day Reading __ A1c ___ | ☐ Yes ☐ No |
| Venereal disease | ☐ Yes ☐ No |
| Thyroid disease | ☐ Yes ☐ No |
| Cancer or cancer treatment Type/Date_____ | ☐ Yes ☐ No |
| Immunosuppressive disorders (AIDS, Lupus, etc.) | ☐ Yes ☐ No |
| Ulcers | ☐ Yes ☐ No |
| Artificial implants, hips, or other | ☐ Yes ☐ No |

**Have you become sick from, shown any allergy to, or have been told not to take the following medications?**

| | |
|---|---|
| Anesthetic such as Novacaine, xylocaine | ☐ Yes ☐ No |
| Antibiotics i.e.Penicillin, Aspirin, Codiene | ☐ Yes ☐ No |
| Other medications or Latex | ☐ Yes ☐ No |

Please list all medicines that you are taking on a regular or daily basis and any restrictions that you may have need or require consultation with your doctor: _____

_____

_____

_____