

PATIENT REGISTRATION

(Please Print)

WHOM MAY WE THANK FOR REFERRING YOU?

DATE

(____)_____
MOBILE PHONE

PATIENT NAME _____
LAST FIRST MIDDLE INITIAL

PREFERRED NAME

STREET ADDRESS

CITY STATE ZIP

EMAIL HOME PHONE (____)_____

SEX M F

AGE

____/____/____
DATE OF BIRTH

- MARRIED
- WIDOWED
- SEPARATED
- DIVORCED
- SINGLE
- MINOR

EMPLOYER/SCHOOL OCCUPATION

SPOUSE/PARENT NAME

WHO IS RESPONSIBLE FOR THIS ACCOUNT RELATIONSHIP TO PATIENT

SOCIAL SECURITY #

P +1.847.290.0222
E info@tokunaga.com

7 E. Golf Road
Arlington Heights
IL 60005

shawntokunagadds.com

MEDICAL HISTORY

(Please Print)

PHYSICIANS NAME

____/____/____
DATE OF LAST PHYSICAL

Have you ever had any of the following? (check boxes that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Artificial Heart Valves or Joints, Screws, etc | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Bleeding Abnormally | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Special Diet |
| <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Venereal Disease |

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? YES NO If so, what? _____

Have you ever responded adversely to medical or dental treatment? YES NO

Are you taking any medication at this time? YES NO
If so, what? _____

Are you under the care of a physician? YES NO
For what conditions? _____

(Women) Do you suspect that you are pregnant? YES NO Due Date _____

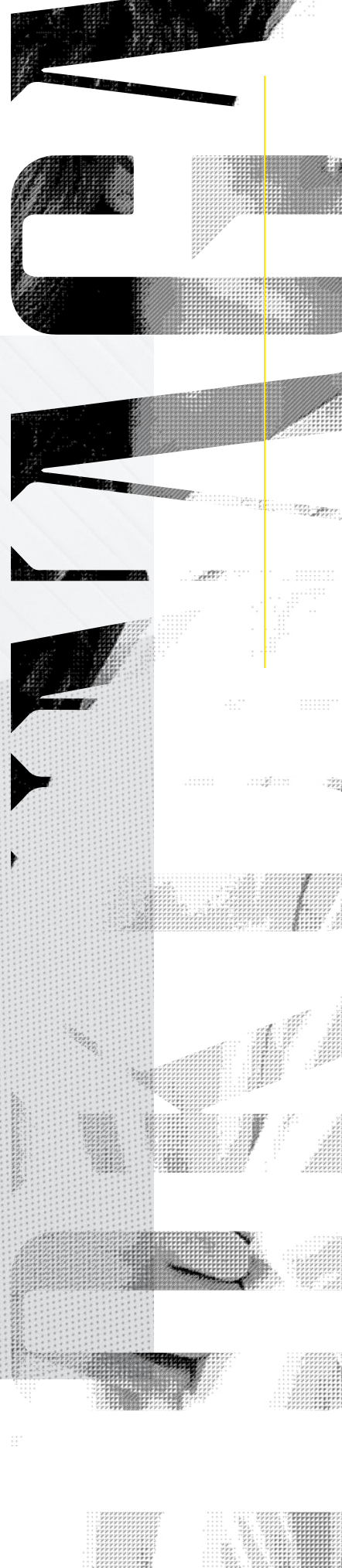
Are you nursing? YES NO

Taking birth control pills? YES NO

Is there anything else we should know about your medical history? _____

TOKUNAGA

SHAWN TOKUNAGA DDS



CERTIFICATION

To the best of my knowledge, the information I have provided on this form is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

SIGNATURE OF PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

DATE

PRINT NAME OF PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

RELATIONSHIP TO PATIENT

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? YES NO

For what conditions? _____

Is the patient taking any new medications? _____ If so, what? _____

DATE

PATIENT SIGNATURE

DATE

DENTIST SIGNATURE

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? YES NO

For what conditions? _____

Is the patient taking any new medications? _____ If so, what? _____

DATE

PATIENT SIGNATURE

DATE

DENTIST SIGNATURE

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? YES NO

For what conditions? _____

Is the patient taking any new medications? _____ If so, what? _____

DATE

PATIENT SIGNATURE

DATE

DENTIST SIGNATURE

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? YES NO

For what conditions? _____

Is the patient taking any new medications? _____ If so, what? _____

DATE

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