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 #

TOKUNAGA

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MEDICAL HISTORY

(Please Print)

_____ PHYSICIANS NAME

____ /____ /____ DATE OF LAST PHYSICAL

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

- ☐ Allergies
- ☐ Arthritis
- ☐ Artificial Heart Valves or Joints, Screws, etc
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chronic Diarrhea
- ☐ Circulatory Problems
- ☐ Congential Heart Lesions
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Hernia Repair
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Recent Weight Loss
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollem Neck Glands
- ☐ Ulcer
- ☐ 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 ____________ PATIENT SIGNATURE ____________

DATE ____________ DENTIST SIGNATURE ____________

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