Pearl District Dental

New Patient Registration

PATIENT INFORMATION

Date:

First Name:

Last Name:

Birth Date:

Address:

City:

State:

Zip:

Home Phone:

Cell Phone:

Work Phone:

Ext.:

E-mail:

SSN:

Best method to reach you

☐ E-mail
☐ Home
☐ Cell
☐ Work

Sex:

○ Male
○ Female

Marital Status:

Occupation:

Employer/School:

Spouse's Name:

Spouse's Employer:

How did you hear about us?

DENTAL INSURANCE

Responsible party and Relationship?

Insurance Co.:

Subscribers Name:

Birthdate:

ID:

Is patient covered by additional insurance?

○ Yes
○ No

ASSIGNMENT AND RELEASE

I assign directly to Mika Miyamoto-Shemali, D.M.D. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand all dental procedures, especially those involving anesthesia, carry certain risks and complications including possible nerve damage and loss of function. I authorize Mika Miyamoto-Shemali, DMD and her assignees to perform such dental procedures as necessary and agree to hold such parties harmless.

Signature of Patient, Parent, Guardian or Personal Representative:

Sign

Relationship to Patient:

IN CASE OF EMERGENCY, CONTACT

(Specify someone who does not live in your household.)

Name:

Relationship:

Home Phone:

Work Phone:

Please indicate current preferred level of dental care:

☐ I wish treatment only when something breaks down or hurts. I am indifferent about keeping my teeth.
☐ I want to keep my teeth but within a certain budget and time frame.
☐ I will do whatever I must to keep my teeth and prefer treatment to be completed in the most lasting fashion possible.

DENTAL INFORMATION

Reason for today's visit

Former dentist

Date of last dental visit

Date of last dental X-rays

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Fingernail biting
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Sensitivity to cold
- ☐ Sensitivity when biting
- ☐ Chew on one side of mouth
- ☐ Cigarette, pipe, cigar smoking
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ Foreign objects
- ☐ Gums swollen or tender
- ☐ Jaw pain or tiredness
- ☐ Sensitivity to heat
- ☐ Sores, growths in mouth
- ☐ Lip or cheek biting
- ☐ Loose teeth, broken fillings
- ☐ Mouth breathing
- ☐ Mouth pain, brushing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to sweets

How often do you floss?

How often do you brush?

	1	2	3	4	5	6	7	8	9	10
Please, indicate your general cleaning preference (circle one)	○	○	○	○	○	○	○	○	○	○

Gentle

Vigorous

	1	2	3	4	5	6	7	8	9	10
How satisfied are you with your smile? (circle one)	○	○	○	○	○	○	○	○	○	○

Extremely dissatisfied

Very satisfied

What would you like to change in the appearance of your teeth?

- ☐ Color
- ☐ Shape
- ☐ Alignment (Straight)
- ☐ Old fillings
- ☐ Closing Space
- ☐ Chips
- ☐ Nothing
- ☐ Other

Other

What type of toothbrush are you currently using?

- ○ Manual
- ○ Electric
- ○ Brand

Brand:

Do you participate in heavy contact sports (basketball, football, boxing, etc)?

Do you play musical wind (wood/brass) instruments regularly?

- ○ Yes
- ○ No

HEALTH INFORMATION

Physician's Name:

Date of last visit:

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).

- ○ Yes
- ○ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- ☐ * Aids/HIV
- ☐ * Allergic to Anesthetics
- ☐ * Allergic to Aspirin
- ☐ * Allergic to Codeine
- ☐ * Allergic to Iodine****
- ☐ * Allergic to Latex
- ☐ * Allergic to Penecillin *****
- ☐ * Allergic to Sulfa
- ☐ Anemia
- ☐ Arthritis Rheumatism
- ☐ Artificial Heart Valves or Joints
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding abnormally (extraction/surgery)
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatities A as a child
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives or Rash
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Skin Rash
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Tumor or Growth on Head or Neck
- ☐ Ulcer
- ☐ Venereal Disease

- ☐ Alzheimer's Disease
- ☐ Angina
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Chest Pains
- ☐ Convulsions
- ☐ Cough, persistent or bloody
- ☐ Hypoglycemia
- ☐ Stomach/ Intestinal Disease
- ☐ Heart Attack / Failure
- ☐ Hay Fever
- ☐ Frequent Headaches
- ☐ Frequent Cough
- ☐ Excessive Thirst
- ☐ Emphysema
- ☐ Shingles
- ☐ Renal Dialysis
- ☐ Rheumatism
- ☐ Spina Bifida
- ☐ Swollen Feet or Ankles
- ☐ Swollen Limbs
- ☐ head or neck
- ☐ Weight Loss, unexplained

Blood Disease

- ○ Yes
- ○ No

Explained: _____

Hepatitis

- ○ Yes
- ○ No

Type: _____

Do you use tobacco?

- ○ Yes
- ○ No

If yes, how much per day _____

For how long? _____

Do you use controlled substances?

- ○ Yes
- ○ No

Do you wear contact lenses?

- ○ Yes
- ○ No

Women:

Are you pregnant?

- ○ Yes
- ○ No

Due date: _____

Taking birth control pills?

- ○ Yes
- ○ No

Are you nursing?

- ○ Yes
- ○ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

Medication Name: _____

Comments/Dosage: _____

Pharmacy Name: _____

Phone: _____

ALLERGIES

- ☐ Barbiturates (Sleeping pills)
- ☐ Acrylic
- ☐ Metal
- ☐ Other

Other: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent or guardian:

Sign