PATIENT CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

NAME:_____ **DATE OF BIRTH:**_____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving.

Physician's Name

When was your last physical?

Address

Phone Number

	YES	NO
Are you in good Health?	☐	☐
Have there been any changes in your general health within the past year?	☐	☐
Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
Please explain._____		
Are you taking any medicine(s)?	☐	☐
Including non-prescription medicine	☐	☐
If yes what medicine(s) are you taking?		

	YES	NO
Are you under the care of a physician?	☐	☐
If yes describe:_____		
Have you had any abnormal bleeding?	☐	☐
Do you bruise easily?	☐	☐
Have you ever required a blood transfusion?	☐	☐
Have you had a recent weight loss?	☐	☐
Do you use tobacco products in any form?	☐	☐
Do you use alcohol?	☐	☐
Do you use illegal substances?	☐	☐
Women only:		
Are you pregnant or think you may be?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐
Periodontal History:		
Have you had periodontal treatment - deep cleanings requiring local anesthesia or gum surgery?	☐	☐
If yes, when and what type of treatment?		

Are you allergic to or have you had reactions to:

	YES	NO
Local Anesthetics like novocaine or epinephrine?	☐	☐
Penicillin, Erythromycin, or other antibiotics?	☐	☐
Sulfa drugs?	☐	☐
Barbiturates, sedatives or sleeping pills?	☐	☐
Other?	☐	☐

	YES	NO
Aspirin?	☐	☐
Iodine?	☐	☐
Latex (have you reacted to blowing up balloons or are you unable to wear band aides)?	☐	☐

PATIENT CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

Do you have or have you ever had the following:

	YES	NO		YES	NO
Rheumatic heart disease or rheumatic fever?	☐	☐	Prolonged Cough 4 or more weeks?	☐	☐
Scarlet Fever?	☐	☐	Coughing Blood?	☐	☐
Heart Defect or heart murmur?	☐	☐	Night Sweats?	☐	☐
Heart trouble, heart attack or angina?	☐	☐	Fevers?	☐	☐
Pacemaker?	☐	☐	Unexplained Weight loss?	☐	☐
Heart Surgery?	☐	☐	Tuberculosis?	☐	☐
High Blood Pressure?	☐	☐	Sinus Trouble?	☐	☐
Low Blood Pressure?	☐	☐	Lung or breathing problems?	☐	☐
Hepatitis, jaundice or liver disease?	☐	☐	Asthma or hay fever?	☐	☐
Stroke?	☐	☐	Hives or skin rash?	☐	☐
Cancer?	☐	☐	Allergies?	☐	☐
Diabetes?	☐	☐	Fainting spells or seizures?	☐	☐
AIDS or HIV infection?	☐	☐	Sexually transmitted diseases?	☐	☐
Thyroid Problems?	☐	☐	Arthritis or rheumatism?	☐	☐
Kidney Trouble?	☐	☐	Joint replacement or implant?	☐	☐
Stomach Ulcer?	☐	☐	Epilepsy?	☐	☐
Leukemia?	☐	☐	Anemia?	☐	☐
Glaucoma?	☐	☐	Any other medical problems?	☐	☐

Please indicate the ***type*** and approximate ***dates*** of previous periodontal treatment, if any: _____

_____

_____

Signature: *I certify that the information listed is complete and accurate.*

_____

Patient, Parent or Guardian Date

Medical History Update:

Date	Comments	Patient Initials
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	

GREGG T. UYEDA, DDS, MS

Periodontics • Implants

PATIENT INFORMATION

NAME_____ _____ _____
LAST FIRST MI MARITAL STATUS SPOUSE NAME / MOBILE #

MAILING ADDRESS_____
STREET / P.O. BOX CITY STATE ZIP

RESIDENCE ADDRESS_____
STREET CITY STATE ZIP

BIRTHDATE_____/_____/_____ TELEPHONE _____ _____ _____
MONTH DAY YEAR HOME / MOBILE # WORK # EMAIL ADDRESS

OCCUPATION_____ EMPLOYER_____ ADDRESS_____

Whom may we thank for referring you to our office?_____

Has any member of your family been treated in our office? ☐ YES ☐ NO _____
NAME

INSURANCE INFORMATION

1. PRIMARY DENTAL INSURANCE_____ ID#_____ Group #_____
SUBSCRIBER NAME_____Self/Spouse/Parent Date of Birth_____ SS#_____
2. SECONDARY DENTAL INSURANCE_____ ID#_____ Group #_____
SUBSCRIBER NAME_____Self/Spouse/Parent Date of Birth_____ SS#_____

Emergency Contact Information

NAME_____RELATIONSHIP_____

ADDRESS_____

CITY/STATE/ZIP_____

TELEPHONE # _____

Person Responsible for Account

NAME_____RELATIONSHIP_____

ADDRESS_____

CITY/STATE/ZIP_____

TELEPHONE # _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I understand that, if I have an unpaid past due balance , I will be responsible to pay to a Collections Agency the past due balance plus an additional 40% of that past due balance. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the Dentist to release my dental histories and other information about my dental treatment to insurance representatives and/or other health professionals.

METHOD OF PAYMENT

◯ Payment in full at each appointment (cash or check).

◯ Payment in full at each appointment (VISA or MC).

◯ I wish to discuss the Dental Office's Financial Policy

X_____ _____ _____
Signature Date Social Security Number

Ala Moana Building 1441 Kapiolani Boulevard, Suite 800 Honolulu, Hawaii 96814 PH:(808)533-7200 FAX:(808)533-1371