PATIENT REGISTRATION AND MEDICAL HISTORY

Please Print)

WELCOME

TO THE OFFICE OF
BRIAN S. KUBO, DDS, INC

Date _____

Home Phone _____
Birthdate _____
Age _____ Sex: M ☐ F ☐

Patient Name _____
Last Name First Name Initial Preferred Name

Social Security # _____ ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Street Address / P.O. Box _____ City _____ State _____ Zip _____

Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Spouse Name _____ Spouse Birthdate _____ Spouse Social Security # _____

Spouse Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Person Responsible for this Account? _____ Relationship to the Patient _____

Name of Dental Insurance Company _____ Group # _____

Subscriber Name _____ Subscriber # _____ Is There Dual Coverage ☐ Yes ☐ No

Dual Insurance Information (if applicable) _____

Whom Should We Call In Case Of An Emergency ? _____ Phone Number _____

Whom May We Thank for Referring You ? _____

Medical History

Physician's Name _____ Date of Last Physical _____

Please describe your current physical health Good ☐ Fair ☐ Poor ☐

Have you ever been seriously ill/hospitalized or had a surgery(s) ☐ Yes ☐ No If yes, explain: _____

Are you taking any medication at this time ? _____ If so, what ? _____

Are you under the care of any Physician at this time? ☐ Yes ☐ No If yes, for what condition _____

(Women) Do you suspect that you are pregnant ? ☐ Yes ☐ No Are you nursing ? _____

Are there any specifics that we should know about your medical history or condition ? _____

Have you ever had any drug allergies or adverse reaction to any medicine (s) ? _____ If so, what? _____

Have you ever had any allergies to fake gold, ie:non-gold jewelry? _____ If yes, please indicate what happened _____

Have you ever responded adversely to any medical or dental treatment ? _____ If yes, please explain _____

Do you smoke or chew tobacco products ? ☐ Yes ☐ No If yes,please notate which, and how much per day _____

Do you consume any alcohol beverages? ☐ Yes ☐ No If yes,please notate what, and how often _____

Are you using, or have you used any weight loss medication,Ie:Fen-Phen? If yes,please notate what, and when _____

Have You Ever Had the Following ? (Please Check the Boxes That Apply):

- ☐ Heart Problems
- ☐ Artificial Heart Valves or Joints
- ☐ Stroke
- ☐ Heart Murmur
- ☐ Congenital Heart Defect
- ☐ Bleeding Problems /Anemia
- ☐ Hemophilia
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Hepatitis, Jaundice
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Rheumatic /Scarlet Fever
- ☐ Epilepsy or Convulsions
- ☐ Treatment for growths/tumors
- ☐ Cancer
- ☐ Radiation Treatment
- ☐ Chronic Diarrhea
- ☐ Ulcer
- ☐ Thyroid Problems
- ☐ General allergies: dust/pollen/ food(ie:milk)/animals/other
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ Sinus Problems
- ☐ Respiratory Diseases
- ☐ Special Diet
- ☐ Recent Weight Loss
- ☐ Psychiatric Care
- ☐ Nervous Problems
- ☐ "A.I.D.S." HIV or Other Immunosuppressive Disorders
- ☐ Venereal Disease
- ☐ Chemical Dependency ie. Alcohol , etc.
- ☐ Arthritis
- ☐ Back Problems
- ☐ Circulatory Problems
- ☐ Kidney/Liver Problems
- ☐ Glaucoma
- ☐ Asthma
- ☐ Headaches
- ☐ Hearing Impairment
- ☐ Handicaps/Disabilities
- ☐ Any other condition or disease not mentioned

(Over)

Dental Questionaire

What was the name of your last dentist ? _____

What brought you to the dentist today ? _____

How long has it been since you've seen a dentist ? _____

What type of treatment was done at that time _____

Were there any complications or problems during your last dental treatment ? ____ If yes, please specify _____

If known, what was the date of your last X-rays ? _____

Are any teeth sensitive to hot / cold / sweets ? ☐ Yes ☐ No If yes, please specify _____

How do you feel about the appearance of your teeth ? _____

Are you happy with the way they look ? ☐ Yes ☐ No If no, please specify _____

Are your teeth comfortable ? ☐ Yes ☐ No If no, please specify _____

Does any area bother you when you chew ? ☐ Yes ☐ No If yes, please specify _____

If you could change anything in your mouth, what would it be ? _____

Do you feel that you may have bad breath ? ☐ Yes ☐ No

Do your jaws frequently pop or click ? ☐ Yes ☐ No

Is there anything about your previous dental experiences you would like to tell me ? ☐ Yes ☐ No If yes, please specify _____

Has your dental treatment in the past been comfortable ? ☐ Yes ☐ No If no, please specify _____

Do you feel that the dental treatment you have had in the past was of lasting value ? ☐ Yes ☐ No If no, please specify _____

To the best of my knowledge, the noted information is accurate and will only be used in regards to my dental treatment, billing and processing of my dental insurance for benefits of which I am entitled. I will not hold my dentist or any member of his staff responsible for any errors or ommisions that I may have made in the completion of this form.

Please note that our office requires at least 24 hours notice for any changes made in your appointments. Failure to do so will incur a cancellation fee of $25.00 per half hour missed.

Date _____ Signature _____

Informed Consent

Permission for Dental Examinations and/or General Treatment

I , _____,do hereby authorize and consent to x-rays, examination, anesthetic, sedative, or dental treatment under the general, direct, or indirect supervision of Dr. Kubo, his associates, or staff members, as he may deem necessary. This authorization will remain in effect until canceled in writing by me.

Note:Risks and Complications: Local anesthesia has risks of allergic reactions, brain damage and death. Fortunately, these damaging reactions seldom occur, however, they always exist.

Privacy of Patient Records: Please be advised that it is the policy of this office to protect the privacy rights of our patients to the fullest extent of the law. Your records will not be shared without your written consent except for our office staff , other dentists within our practice, and your designated insurance company, if applicable.

Date: _____

Patient Signature: _____

Print Name : _____

Witness Signature: _____

Print Name: _____