Glenn Fujinaka, D.D.S. Inc.
Periodontics • Oral Implantology

PATIENT HISOTRY AND INFORMATION

Please Print Clearly

Name _____ Today's Date _____
Birthdate _____ Age _____
Address _____
City _____ State _____ Zip _____
Home Phone: _____ Cell Phone _____
Email _____
Occupation _____ Employer _____
Business Address _____ Phone _____
SS# _____ Driver's License # _____
Name of Spouse _____ Employer _____
Occupation _____ Business Address _____
If you are a Student, Name of School _____
Names of other family members who are patients in our Practice _____
Referred to this office by _____

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING

Name of Insured: Patient ☐ Spouse ☐ Both ☐

Name of Dental Insurance: _____ Name of Dental Insurance: _____
_____ _____
Name of Dental Group _____ Name of Dental Group _____
Group # _____ Group # _____
Union Local # _____ Union Local # _____
Social Security # _____ Social Security # _____

MEDICAL AND DENTAL HISTORY

Name of general dentist _____ Date of last examination _____
What is your immediate dental problem? _____
Medical Doctor _____ Phone _____
Address _____ Medical ID # _____
When did you last consult a physician? _____
Reason: _____
Have you been a patient in a hospital in the past 2 years? Yes No
Reason: _____
Are you seeing a specialist? Yes No Name: _____
Reason: _____

Although we 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 you will receive.
Thank you for answering the following questions.

Do you have, or have you had, any of the following?

	Yes	No		Yes	No
Autoimmune Disease	□	□	Alzheimer's Disease	□	□
Heart Disease, Heart Attack, Pacemaker	□	□	Liver or Kidney Disease	□	□
High Blood Pressure	□	□	Hepatitis, Jaundice	□	□
Heart Murmur, Rheumatic Fever*	□	□	Venereal Disease	□	□
Mitral Valve Prolapse*	□	□	Prosthetic Heart Valves, Hip or Joints*	□	□
Diabetes, Hypoglycemia	□	□	Respiratory Disease,Asthma,TB,Emphysema	□	□
Smoke	□	□	AIDS or HIV Positive	□	□
Epilepsy	□	□	Allergies:……	□	□
Fainting	□	□	a. Penicillin ……	□	□
Psychiatric Treatment	□	□	b. Other Antibiotics ……	□	□
Arthritis	□	□	c. Latex …….	□	□
Tumor History or Cancer	□	□	d. Other ……..	□	□
Radiation, Chemotherapy	□	□	Are you taking medication for osteoporosis…	□	□
Glaucoma	□	□	If yes, what are you taking ……...		
Endocrine Disease	□	□			

Women: Are you □ Pregnant/Trying to get pregnant □ Nursing □ Taking oral contraceptives? □ □
Have you had excessive bleeding requiring treatment? If yes list under remarks …… □ □
Have you taking medicine, drugs or pills regularly? If yes list under remarks …… □ □
Have you experienced any unfavorable reaction to previous dental treatment? If yes list under remarks
Is there anything in your medical history that has not been asked? If yes list under remarks ……...
*Condition may require medication
Remarks _____
_____
_____
_____
_____
_____

Acknowledgement and Authority
I consent to treatment as necessary or desirable to the care of the first named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending doctor, or his nurse or qualified designate.
Unless other arrangements are made with the Financial Secretary, I also acknowledge full responsibility for payment of such services and agree to pay for them, in full, AT THR TIME OF SERVICE. I understand that a fee of $125.00 will be charged for missed appointments without 24 hours prior notice.

Signed _____ Date _____
Patient, Parent, or agent (Must be 18 years or older)