Ted T. Sakamoto, DDS

Restorative & Family Dentistry

Patient Information

Last Name_____ First Name _____ M.I. _____

Address _____ City _____ State_____ Zip _____

Home # ( ) _____ Cell# ( ) _____ Work # ( ) _____

Birthdate _____ Gender _____ Marital Status _____

Occupation _____ Employer _____ Student: Yes/No School _____

Email _____ Name of Person Who Referred You_____

Financially Responsible Party (if different from patient)

Last Name _____ First Name _____ M.I. _____

Address _____ City _____ State _____ Zip_____

Occupation _____ Employer _____ Work # _____

Home # _____ Cell # _____ Email _____

Dental Insurance

Primary Insurance: _____

Subscriber Name: _____

Subscriber Birthdate: _____

Subscriber # _____ Group # _____

Relationship to Patient:

☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner

Secondary Insurance: _____

Subscriber Name: _____

Subscriber Birthdate: _____

Subscriber # _____ Group # _____

Relationship to Patient:

☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner

Payment for services rendered and unpaid by dental insurance (copayment) will be due at the end of each appointment. We accept cash, check, and major credit cards. If you require financing, third-party financing can be provided for qualified individuals.

Physician's Name _____ Date of Last Visit _____

1. □ Yes □No Have you ever been hospitalized? If yes, why? _____
2. □ Yes □No Have you ever had an operation? If yes, why? _____
3. □ Yes □No Do you have any allergies? Please List _____
4. □Yes □No Do you take medications? Please List _____
5. □Yes □No Have you had a heart attack, chest pain, by-pass surgery, artificial pacemaker/defibrillator ? Please explain_____
6. □Yes □No Do you have high blood pressure?
7. □Yes □No Do you have artificial heart valves?
8. □Yes □No Have you had rheumatic fever or rheumatic heart disease?
9. □Yes □No Do you have or have you had tuberculosis (TB)?
10. □Yes □No Do you have or have you had asthma, emphysema, bronchitis or pneumonia?
11. □Yes □No Do you or have you ever had hepatitis or liver disease?
12. □Yes □No Do you have diabetes?
13. □Yes □No Do you have kidney disease or had a kidney transplant?
14. □Yes □No Does it take long for bleeding to stop if you get a cut?
15. □Yes □No Have you ever had a stroke?
16. □Yes □No Have you ever had epilepsy or seizures?
17. □Yes □No Have you ever had fainting/dizzy episodes?
18. □Yes □No Have you ever had cancer?
19. □Yes □No Have you ever had radiation or chemotherapy?
20. □Yes □No Do you use recreational drugs (crystal meth, cocaine, etc)
21. □Yes □No Are you undergoing psychiatric treatment?
22. □Yes □No Do currently have an infectious disease?
23. □Yes □No Do you have arthritis?
24. □Yes □No Are you or have you ever taken medications to treat osteoporosis?
25. □Yes □No For women: Are you pregnant, taking birth control pills or nursing?

Dental History

1. When was your last dental check up? _____
2. When was your last dental x-ray? _____
3. How often do you brush? _____How often do you floss? _____
4. □Yes □No Do you currently have tooth or dentally related discomfort?
5. □Yes □No Do you currently have broken fillings or teeth?
6. □Yes □No Do your gums bleed easily when brushing or flossing?
7. □Yes □No Do you clench or grind your teeth?
8. □Yes □No Do you smoke or use chewing tobacco?
9. □Yes □No Do you have mouth sores or ulcers?
10. □Yes □No Do you have pain in or locking of the jaw joint (TMJ)?

Is there anything else we should know about your medical/dental history? _____

This form has been completed to the best of my knowledge and I authorize the disclosure of my patient record for the purpose of treatment, payment and healthcare operations.

Signature of Patient/Guardian_____ Date: _____