Howe Dental Care
Kenneth Yasuda D.D.S.
Caring for you and your teeth

Patient Registration

Patient Information

Today's Date__________________________

Name:____ Preferred Name:__________________________________

Address:____

City/State/Zip:____

Hm Phone:____ Cell Phone:____

DOB:____________________________________ SSN____

Check Appropriate
____Minor _____Single ______Married _____Divorced _____Widowed ______Separated

Sex:
____M ____F

Insurance Information

Insurance Carrier:____

ID#____

Subscriber Name:____

Subscriber DOB (if different than patient)______________________________________

Subscriber SSN (if different than patient)_______________________________________

Additional Dental Coverage? ____Yes ____No

Insurance Carrier____

ID#____

Subscriber
Name____

Subscriber DOB_________________________________

Subscriber SSN__________________________________

If patient is a minor who is the Responsible Party?

Name:____

Hm Phone____ Cell Phone____

Relationship to Patient:____

Emergency Contact:____ Ph #______________________________

Pharmacy of Choice:____

Who may we thank for referring you____

Reason for your visit today____

____

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Health History

Please Circle all that apply

Abnormal Bleeding	C.O.P.D	HPV	Radiation Therapy
Acid Reflux/Ulcers	Colitis	Heart Attack	Rheumatic Fever
Alcohol Abuse	Congenital Heart Defect	Heart Surgery	Seizures
Allergies/Hay fever	Diabetes	Hemophilia	Shingles
Anemia	Drug Abuse Therapy	Hepatitis A B C	Sickle Cell or Trait
Angina Pectoris	Epilepsy	High Blood Pressure	Sinus Problems
Arthritis	Fainting Spells	High Cholesterol	Sleep Apnea/Snoring
Artificial Heart Valve	Fever Blisters	Kidney Problems	Stroke
Artificial Joint	Fosomax/Boniva	Liver Problems	Taken Redux/Fen-Phen
Asthma	Frequent Headaches	Mental Health Treatment	Thyroid Problems
Blood Transfusion	Glaucoma	Mitral Valve Prolapse	Tuberculosis
Cancer-Chemotherapy	HIV +/AIDS	Pacemaker	

Allergies

Please Circle all that apply

Aspirin	Dental Anesthetics	Jewelry	Metals	Sulfa
Codeine	Erythromycin	Latex	Penicillin	Tetracycline

Please list any additional
allergies____

____

Are you taking any medications? If so, please list below or provide a list

Medication	Dose	When Taken	Condition

Do you need antibiotics prior to dental treatment? _____Yes _____No

If yes please explain:____

Medication/Dosage:____

Do you smoke or Chew Tobacco? _____Yes ______No
If yes, What product (i.e. Cigarette, cigar, e-cigarette, vaporizer, marijuana)?_________________________________
How frequently?______________________________

Women Only
Are you taking birth control pills? ____Yes _____No
Are you pregnant? _____Yes _____ No
If yes what week?__________________
Are you nursing? _____ Yes ______No

Do you have any other diseases or medical conditions we should be aware of? ____Yes ____No
If yes please
explain:____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the dental office of any changes in my medical status and/or other information. I authorize the dentist to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Yasuda, with patients consent, to make a thorough diagnosis of the patient's dental needs. I authorize the dental team at Dr. Kenneth Yasuda's to release information such as the diagnosis and records of any treatment or examination, during the period of such dental care to a third party payers and/or other health practitioners. I understand that my dental insurance carrier may pay less than the actual fee for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

____
Signature Date Relationship to patient