Health History

Patient Name_____ **Date of Birth**_____

Reason for today's visit?_____

Former Dentist_____ City/State _____ Date of last exam, cleaning and x-rays _____

How often do you floss? _____ How often do you brush? _____

Do you have dental anxiety? Please explain _____

Please circle Y for yes or N for no to indicate if you have had any of the following:

Acid Reflux/GERD	Y	N	Fingernail biting	Y	N
Bad Breath	Y	N	Tobacco use (Type _____)	Y	N
Dry Mouth	Y	N	Foreign objects-piercings in or around the mouth	Y	N
Mouth Breathing	Y	N	Food collection between teeth	Y	N
Bleeding gums	Y	N	Broken teeth or fillings	Y	N
Swollen or tender gums	Y	N	Mouth pain when brushing	Y	N
Sore or growths in mouth	Y	N	Sensitivity to cold	Y	N
Periodontal(gum) treatment or surgery	Y	N	Sensitivity to heat	Y	N
Loose teeth	Y	N	Sensitivity to sweets	Y	N
Burning sensation on tongue	Y	N	Sensitivity to biting	Y	N
Clicking or popping jaw	Y	N	Wisdom teeth removal	Y	N
Jaw pain or tiredness	Y	N	Orthodontic treatment	Y	N
Grinding or clenching teeth	Y	N	Orthodontic retainers please specify _____	Y	N
Pain around ear	Y	N	Other _____	Y	N

Medical History

Physician's Name_____ Date of last visit _____

If female, are you pregnant? _____ Weeks _____ Due Date _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include a combination of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes _____ No _____

Please circle Y for yes or N for no to indicate if you have had any of the following:

AIDS/HIV	Y	N	Epilepsy	Y	N	Respiratory Disease	Y	N
Anemia	Y	N	Fainting or dizziness	Y	N	Rheumatic Fever	Y	N
Arthritis, Rheumatism	Y	N	Glaucoma	Y	N	Scarlet Fever	Y	N
Artificial Heart Valves	Y	N	Headaches	Y	N	Sinus Trouble	Y	N
Artificial Joints	Y	N	Heart Murmur	Y	N	Skin Rash	Y	N
Asthma	Y	N	Heart Problems	Y	N	Special Diet	Y	N
Back Problems	Y	N	Hepatitis Type _____	Y	N	Stroke	Y	N
Bleeding Problems	Y	N	Herpes	Y	N	Swollen Feet or Ankles	Y	N
Blood Disease	Y	N	High Blood Pressure	Y	N	Swollen Neck Glands	Y	N
Cancer	Y	N	Jaundice	Y	N	Thyroid Problems	Y	N
Chemical Dependency	Y	N	Kidney Disease	Y	N	Tonsillitis	Y	N
Chemotherapy	Y	N	Liver Disease	Y	N	Tuberculosis	Y	N
Circulatory Problems	Y	N	Low Blood Pressure	Y	N	Tumor or growth	Y	N
Cortisone Treatments	Y	N	Mitral Valve Prolapse	Y	N	Ulcer	Y	N
Cough, persistent or bloody	Y	N	Pacemaker	Y	N	Sexually Transmitted Infection	Y	N
Diabetes	Y	N	Psychiatric Care	Y	N	Weight Loss, unexplained	Y	N
Emphysema	Y	N	Radiation Treatment	Y	N	Other	Y	N

Other things to know that aren't listed:

Medications

List any medications or herbal supplements you are currently taking and why:

_____

_____

_____

Pharmacy Name _____

Phone _____

Allergies

___No Known Drug Allergy

___Aspirin ___Barbiturates(sleeping pills)

___Codeine ___Iodine

___Latex ___Local Anesthetic

___Penicillin ___Sulfa

Other_____

Notice Of Privacy Practices

Aspire Dental and its staff are dedicated to serving their patients with professionalism and care while, at all times, protecting the privacy and security of all health information. During the course of treatment it may be necessary to share information with health care professionals or business associates. The following are examples of instances where information may be shared:

- Radiographs and treatment information may be forwarded to specialists if a referral is needed.
- Disclosure of health or dental information when required by law.
- Forwarding radiographs and chart notes to your insurance company for payment purposes.
- For collection purposes, payment history or financial agreements may be forwarded to the proper agency for collecting.
- Disclosure of health information to provide you with reminders such as voicemail messages, postcards, letters, e-mails, or text messaging.

HIPAA DISCLOSURE ACKNOWLEDGEMENT

I understand and agree to the above disclosures and have had a chance to ask questions regarding this notice. I understand that a policy is available for me to read and I may receive a copy for my records if necessary.

_____

Signature Date

_____

Doctor Signature Date

_____

Hygienist Signature Date Staff Initial

Patient Registration

Patient Information

Name: First _____ MI__ Last _____

Preferred Name _____

Address _____

City/State/Zip _____

Home/Work # _____Mobile # _____

E-Mail Address_____

SS# _____ Birth Date _____

Driver's License #_____

Sex: Male ___ Female ___ Other _____

Status: Married ___Domestic Partner___ Single ___Minor ___

Employer/School _____

Occupation _____

Spouse/Domestic Partner _____

SS# _____ Birth Date _____

Home # _____ Mobile # _____ Work # _____

Employer/School _____

Whom may we thank for referring you?

_____

E-mail and Texting Correspondence Disclosure

Aspire Dental sends all appointment reminders for cleanings, check-ups, appointments and other communication via email and phone correspondence. We also offer text messaging appointment reminders. I understand that certain charges may apply according to my internet/phone carriers and that Aspire Dental is not responsible for such charges.

I understand that I can opt out of e-mail communication and can opt in to text communication.

_____

Signature of Patient/Guardian

_____

Date Relationship to Patient

Dental Insurance

Primary Insurance Company _____

Subscriber's Name _____

SS# _____ Birth Date _____

Relationship to Patient _____

ID# _____

Group # _____

Insurance Phone # _____

Are you covered by a secondary insurance Y / N

Secondary Insurance Company _____

Subscriber's Name _____

SS# _____ Birth Date _____

Relationship to Patient _____

Secondary Insurance _____

ID# _____

Group # _____

Insurance Phone # _____

Assignment and Release of Insurance Benefits

I certify that I, and/or my dependent(s), have insurance coverage with the listed insurance company, or companies, and assign directly to Dr. Lisa Kakishita DMD LLC DBA Aspire Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Aspire Dental may use my health care information and may disclose such information to the above-named Insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____

Signature of Patient/Guardian

_____

Date Relationship to Patient

Emergency Contact

Name _____ Relationship _____

Home #_____ Work #_____ Mobile # _____

Financial Agreement

In order to assist you in making payments for your dental treatment, several options are available. Payments may be made by cash, check, credit card, or Care Credit. We reserve the right to charge a $25.00 fee for all checks returned for non-sufficient funds. Unless other arrangements have been made, **your balance is due at the time services are rendered.**

If you have dental insurance, as a courtesy, we will bill your insurance carrier directly. Dental insurance rarely covers 100% of services rendered; therefore please be prepared to pay your co-pay at each visit. Aspire Dental is happy to provide an estimate for your co-pay prior to your visit. This is an estimate only and you will be responsible for any amounts not reimbursed by your dental insurance.

Scheduled appointments are reserved specifically for you. If you need to change an appointment, please contact the office with at least 48 hours notice. **There will be a $45.00 fee for appointments cancelled without 48 hour notice.**

We realize that time is very important to you, and we make every effort to stay prompt. We ask that you have the same consideration by being on time for your appointments.

Please do not hesitate to ask any questions you may have concerning office policies. We welcome open communication with you and wish to develop a relationship of friendship and trust. Our goal is to meet your dental needs while offering you the most comfortable and enjoyable dental experience.

_____

Signature of Patient or Guardian Relationship to Patient Date