Today's date:_____Patient I

Patient Information for Children



					<i>0</i>	_		
First name:		Middle in	tial: Last name:			_		
			Male Female					
			City/Zip code					
Parent's/Guardian's na	mae (firet & last	١.						
Long #	iiiles (iiist & iast)		Call #:		-		
				_ Cell #		-		
Email:				Lywhau via amail?	Voc. No.	-		
	=		Is it okay to correspond	=				
Employer:			Occupation:			-		
Whom may we thank for	or referring you?					_		
If applicable, when is y	our approximate	PCS date?				_		
Person to contact in ca	ise of an emergi	encv						
	_	-	Relationship:					
			rtciationomp.					
110111C #.		WOIN #				<u>-</u>		
Dental Insurance								
Primary Carrier		Domai	in our arroo					
			Phone	#:		_		
Subscriber's name:			Subscr	iber ID #:				
			Subscriber's relationship					
						-		
Secondary Carrier			Phone	#•				
			Subscr					
-			Subscriber's relationship	•				
			and also responsible for payin			/		
insurance does not cover. I hereby authorize payment directly to Kanemaru Family Dental insurance benefits otherwise payable to me. I								
understand that I am responsible for all costs of dental treatment or examination rendered, to my insurance company. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my								
knowledge. Should further information be needed, you have my permission to the respective healthcare provider or agency that may release								
SUC	ch information to yo	ou. I will notify Dr. Kane	emaru of any changes in my he	ealth or medication.				
Signature:			Date:					
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FOR OFFICE USE:								
Date:	_Initial:	Changes:				_		
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Date:	_Initial:	Changes:				_		
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Date:	_Initial:	Changes:				_		
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Date:	_ Initial:	Changes:				_		

Medical History							
Have you been hospitalized or under the care of a medical doctor during the past 2 years? Yes No If YES, for							
what?		-					
Physician's name:Phone:							
Are you currently taking any medications or drugs? Yes No If YES, Please List:							
		_					
Do you have heart problems? Yes No If YES, please specify:							
Do you smoke/use tobacco? Yes No If YES, how many per day?							
For Women: Are you pregnant or think that you may be pregnant?	Yes No if YES, what month?						
Please check either "Yes" or "No	for each of the following						
Indicate which of the following you have had or have at present:							
Surgeries: Cancer/ Chemotherapy	YesNo Kidney TroubleYes	No					
HeartYesNo Chest Pain	YesNo Liver DiseaseYes	_					
Joint/bone surgeryYesNo Cold Sores/ Herpes	YesNo LupusYes	_No					
Joint ReplacementYesNo Colitis	YesNo Nervousness/AnxietyYes						
Heart (Disease, Attack)YesNo Cortisone Medicine	YesNo Neurological DisordersYes						
Mitral Valve ProlapseYesNo Difficulty Breathing	YesNo Psychiatric /Psychological CareYes						
Heart Murmur — Yes — No Drug Addiction	—Yes —No Radiation Therapy —Yes —						
Heart PacemakerYesNo Eating Disorder	YesNo Rheumatic/Scarlet FeverYes YesNo Shingles/ Chicken PoxYes						
Artificial Heart ValveYesNo Emphysema DiabetesYesNo Epilepsy or Seizures	YesNo Shingles/ Chicken PoxYes YesNo Sickle Cell Disease/TraitsYes						
DiabetesYesNo Epilepsy or Seizures Allergies or HivesYesNo Fainting or Dizzy Spells	YesNo Sinus TroubleYes						
AIDS / HIVYesNo Frequent Headaches	YesNo Snoring/Sleep ApneaYes						
Alcohol AddictionYesNo Glaucoma	Yes—No Stomach Problems/ UlcersYes						
AnemiaYesNo Hay Fever	YesNo StrokeYes						
Arthritis / RheumatismYesNo Hemophilia/Abnormal Bleeding	YesNo Thyroid ProblemsYes	_No					
AsthmaYesNo Hepatitis A B C	YesNo Tuberculosis (TB)Yes	_No					
Blood DiseaseYesNo High Cholesterol	YesNo TumorsYes						
Blood TransfusionYesNo High or Low Blood Pressure	YesNo Other:						
Bruise EasilyYesNo Jaundice	YesNo						
Are you aware of having an allergic (or adver	se) reaction to any of the following:						
AspirinYesNo Erythromycin	YesNo SedativesYesNo						
	YesNo Sulfa DrugsYesNo						
Anesthetics (ex. Novocaine)—Yes —No Jewelry/Metals							
Penicillin —Yes —No Latex	YesNo Other:						
le there are this are an until like Dr. Karamanu ta karaw that w	and anciet we in mandaling you with a state of increase 2						
Is there anything you would like Dr. Kanemaru to know that would assist us in providing you with outstanding care? (Example: "I gag easilydo not recline me too far")							
(Example: 1 gag easilydo no	or recline the too far)						
		_					
		_					
		_					
		_					