Kahului Office Center
140 Hoohana St. Suite 301
Kahului, HI 96732

Lance D. Ogata, DDS, Inc

808-877-8090
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Please answer all questions on **both** sides, so that we may diagnose your oral health as accurately as possible. All information will be kept strictly confidential. Thank You.

PATIENT'S NAME ______________________________ Preferred Name ________________

❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

❑ Male ❑ Female Social Security No. _____-_____-_____ Birthdate ____/____/____

Mailing Address ______________________________ Home Phone (____)_____-______

City ____________________ State ____________ Zip Code ____________

Cell (____)_____-______ Fax (____)_____-______ Email ____________________

Whom may we thank for referring you? ______________________________

Name of Spouse ________________ Birthdate ____/____/____ Social Security No. _____-_____-_____

Patient Occupation ________________ Employer ________________ Work Phone (____)_____-______

Spouse Occupation ________________ Employer ________________ Work Phone (____)_____-______

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Employee ______________________	Employee ______________________
Employer ______________________	Employer ______________________
Insurance Co. ____________ Group# ________	Insurance Co. ____________ Group# ________
Employee's S.S. No. _____-_____-_____	Employee's S.S. No. _____-_____-_____

Person responsible for payment: ______________________________

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IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name ____________________ Home Ph. No(____)_____-______ Work Ph. No.(____)_____-______

Relationship to Patient ______________________________

DENTAL HISTORY

Chief dental concern: ______________________________
____

Are you nervous about having dental treatment? ❑ Yes ❑ No
Have you ever had a bad dental experience? ❑ Yes ❑ No
Do you have difficulty or pain when opening (yawning)? ❑ Yes ❑ No
Does your jaw get stuck, locked or "go out"? ❑ Yes ❑ No
Difficulty / pain when chewing, talking, or using your jaws? Teeth? ❑ Yes ❑ No
Do you have noises in your jaw joints? ❑ Yes ❑ No
Pain about the ears, temples or cheeks? ❑ Yes ❑ No
Does your bite feel uncomfortable or unusual? ❑ Yes ❑ No
Have you had a recent injury to your head / jaw? ❑ Yes ❑ No
Have you been treated for a jaw joint problem? ❑ Yes ❑ No
Do your teeth ever feel loose? ❑ Yes ❑ No
Does food catch in-between your teeth? ❑ Yes ❑ No
How often do you brush?______ Floss?______ ❑ Yes ❑ No
Any difficulty chewing your food? ❑ Yes ❑ No
Have you ever had periodontal disease? ❑ Yes ❑ No
Are your teeth sensitive to cold / heat / etc? ❑ Yes ❑ No
Have you ever been premedicated for dental work? ❑ Yes ❑ No
Do you have frequent Headaches? ❑ Yes ❑ No
Are you happy with the way your smile looks? ❑ Yes ❑ No
If not, what would you change? ______________________________
____
____

HEALTH HISTORY

Are you having any pain or discomfort at this time? ❑ Yes ❑ No
Do you smoke or use tobacco in any form? ❑ Yes ❑ No
Have you been hospitalized in the past 2 years? ❑ Yes ❑ No
Have you been under the care of a medical doctor during the past 2 years? ❑ Yes ❑ No
Physician Name ______________________________
Address ______________________ Phone:______________
Are you currently taking any medications / drugs? ❑ Yes ❑ No
If yes, please list: ______________________________
List Medications: ______________________________
____
____
Women: Are you pregnant? ❑ Yes ❑ No
Please list any serious medical condition(s) that you have/had:
____

Please check "Yes or No" to the following conditions:

Y N
❑ ❑ Angina Pectoris
❑ ❑ Heart Disease / Attack / Stroke
❑ ❑ Heart Failure
❑ ❑ High / Low Blood Pressure
❑ ❑ Congenital Heart Defect
❑ ❑ Heart Murmur / Rheumatic Fever
❑ ❑ Heart Surgery
❑ ❑ Heart Pacemaker
❑ ❑ Artificial Heart Valve
❑ ❑ Diabetes
❑ ❑ Blood Transfusion / Anemia

Y N
❑ ❑ Sickle Cell Disease
❑ ❑ Bruise Easily
❑ ❑ Hemophilia
❑ ❑ Liver Disease / Yellow Jaundice
❑ ❑ Kidney Failure/Disfunction
❑ ❑ Thyroid Disease
❑ ❑ Ulcers
❑ ❑ Glaucoma
❑ ❑ Chemotherapy / Cancer
❑ ❑ X-ray / Cobalt Treatment
❑ ❑ Cosmetic Surgery

Y N
❑ ❑ Emphysema / Asthma
❑ ❑ Cough / Tuberculosis (TB)
❑ ❑ Arthritis / Rheumatism
❑ ❑ Cortisone Medicine
❑ ❑ Venereal Disease
❑ ❑ A.I.D.S. / H.I.V.
❑ ❑ Hepatitis: A B C **(circle one)**
❑ ❑ Frequent Headaches
❑ ❑ Pain in Jaw Joint
❑ ❑ Artificial Joints (Hip, Knee)
❑ ❑ Scarlet Fever

Y N
❑ ❑ Fever Blisters / Cold Sores
❑ ❑ Fainting / Dizzy Spells
❑ ❑ Epilepsy / Seizures
❑ ❑ Hay Fever / Sinus Trouble
❑ ❑ Allergies / Hives
❑ ❑ Shingles
❑ ❑ Nervousness
❑ ❑ Psychiatric Treatment
❑ ❑ Drug / Alcohol Addiction
❑ ❑ Blood thinner
❑ ❑ Splenectomy

Are you allergic to or have you reacted adversely to the following?

❑ Antibiotics
❑ Codeine
❑ Metals / Jewelry
❑ Aspirin
❑ Latex
❑ Local/Dental Anesthetic

Are you aware of being allergic to any other medications or substances? If yes, please list:

____
____
____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I also give permission to Lance D. Ogata and his staff to use any photos taken for lecturing and continuing education purposes.

Signature ______________________________ Date ______________

Medical History Update
(For Office Use Only)

Date ________ Comments ______________________ Date ________ Comments ______________________
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