

# NORMAN H. NISHIKAWA, D.D.S.

Forest Office Park  
14655 Bel-Red Road, #F103  
Bellevue, Washington 98007  
Telephone: (425) 641-1902

Today's Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## PATIENT INFORMATION

Patient's Last Name	First	Middle	Preferred Name / Nickname		
Birthdate / /	Social Security Number	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Mr. <input type="checkbox"/> Dr.	<input type="checkbox"/> Ms. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Street Address			Home Phone ( )		
City		State	Zip	Cell Phone ( )	
Email Address	Occupation	Employer		Work Phone ( )	
How did you hear about our office? <input type="checkbox"/> Family <input type="checkbox"/> Friend/Coworker <input type="checkbox"/> Insurance Directory <input type="checkbox"/> Internet/Email <input type="checkbox"/> Flyer/Direct Mailing <input type="checkbox"/> Outdoor Signs <input type="checkbox"/> Marketing Representative					
Whom may we thank for referring you to your practice?			Other Family Members Seen Here		

## INSURANCE

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill			Relationship to Patient		
Birthdate / /	Social Security Number	Email Address		Home Phone ( )	
Street Address (if different)			Cell Phone ( )		
City		State	Zip	Work Phone ( )	
Primary Insurance Company		Subscriber's Name		Group #	
Secondary Insurance Company		Subscriber's Name		Group #	

## DENTAL HISTORY

Reason for Today's Visit <input type="checkbox"/> Routine Exam/Cleaning <input type="checkbox"/> Pain/Emergency <input type="checkbox"/> Consultation <input type="checkbox"/> Other _____					
Are you in pain? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, how long? _____					
Please indicate any of the following problems:					
<input type="checkbox"/> Red, swollen or bleeding gums	<input type="checkbox"/> Broken/chipped tooth	<input type="checkbox"/> Bad breath			
<input type="checkbox"/> Sensitive teeth or gums	<input type="checkbox"/> Lost/broken filling(s)	<input type="checkbox"/> Stained teeth			
<input type="checkbox"/> Sensitive to heat	<input type="checkbox"/> Teeth grinding	<input type="checkbox"/> Blisters/sores in or around the mouth			
<input type="checkbox"/> Sensitive to cold	<input type="checkbox"/> Ringing in ear	<input type="checkbox"/> Discomfort, clicking or popping in jaw			
Do you require pre-medication (antibiotics prior to dental treatment)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know					
Previous Dentist		City, State		Phone	
Last Dental Visit			Last X-Rays		
Reasons for changing dentist: <input type="checkbox"/> Moved <input type="checkbox"/> Changed insurance <input type="checkbox"/> Not satisfied with previous dentist <input type="checkbox"/> Referred to our office <input type="checkbox"/> Other _____					

# MEDICAL HISTORY

Name of Primary Physician

Physician's Phone

( )

Please indicate if you have or ever had any of the following diseases or medical conditions:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Heart Attack / Stroke     | <input type="checkbox"/> Stomach Problems / Ulcers      | <input type="checkbox"/> Severe/Frequent Headaches      |
| <input type="checkbox"/> Heart Surgery / Pacemaker | <input type="checkbox"/> Psychiatric Problems           | <input type="checkbox"/> Frequent Neck Pain             |
| <input type="checkbox"/> Heart Murmur              | <input type="checkbox"/> Venereal Disease               | <input type="checkbox"/> Shingles                       |
| <input type="checkbox"/> Rheumatic Fever           | <input type="checkbox"/> Alcohol / Drug Abuse           | <input type="checkbox"/> Asthma                         |
| <input type="checkbox"/> Mitral Valve Prolapse     | <input type="checkbox"/> Tuberculosis (TB)              | <input type="checkbox"/> Difficulty Breathing           |
| <input type="checkbox"/> Artificial Valves         | <input type="checkbox"/> Jaw Problems (TMJ / TMD)       | <input type="checkbox"/> Diabetes                       |
| <input type="checkbox"/> Heart Disease             | <input type="checkbox"/> Cancer / Tumor                 | <input type="checkbox"/> Anemia                         |
| <input type="checkbox"/> Congenital Heart Defect   | <input type="checkbox"/> Chemotherapy / Radiation       | <input type="checkbox"/> Low Blood Pressure             |
| <input type="checkbox"/> Chest Pains               | <input type="checkbox"/> Hepatitis                      | <input type="checkbox"/> High Blood Pressure            |
| <input type="checkbox"/> Scarlet Fever             | <input type="checkbox"/> HIV+ / AIDS                    | <input type="checkbox"/> Bleeding Problems              |
| <input type="checkbox"/> Kidney Problems           | <input type="checkbox"/> Arthritis / Rheumatism         | <input type="checkbox"/> Glaucoma                       |
| <input type="checkbox"/> Liver Problems            | <input type="checkbox"/> Artificial Bones / Joints      | <input type="checkbox"/> Back Problems                  |
| <input type="checkbox"/> Respiratory Problems      | <input type="checkbox"/> Emphysema                      | <input type="checkbox"/> Other Medical Conditions _____ |
| <input type="checkbox"/> Sinus Problems            | <input type="checkbox"/> Fainting / Seizures / Epilepsy |   |

Please list all medications you are currently taking:

Are you allergic to any of the following?

- |                                      |                                     |  |
|--------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Aspirin     | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Local Anesthetics       |
| <input type="checkbox"/> Ibuprofen   | <input type="checkbox"/> Codeine    | <input type="checkbox"/> Other Medications _____ |
| <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Latex      |  |

Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, what form? _____	How much? _____	How long? _____
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<b>For Women:</b> Are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how long? _____	Are you nursing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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## IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	
Home Phone ( )	Cell Phone ( )	Work Phone ( )

- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 60 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize and give consent to perform any necessary or advisable services during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

**X**

PATIENT/GUARDIAN SIGNATURE

DATE