miyamoto
DENTAL DESIGN SUITE INC
Advanced Cosmetic & Restorative Dentistry · TMJ Disorders
1885 MAIN STREET · SUITE 203 · WAILUKU, HAWAII 96793 · 808-242-7007
miyamotodds@hawaii.rr.com · mymauidentist.com
Michael R. Miyamoto, DDS

Welcome to our dental office. We appreciate the trust you have placed in us, and we will strive to provide the high quality of dental care that you expect. The focus of our practice is health-centered, preventative dentistry. We enjoy helping people actively participate in their own health care and control the causes of dental disease. Further, we emphasize aesthetic, adult restorative treatment designed for long-term beauty, comfort, function and low maintenance.
Our staff members are devoted to making your appointments as pleasant and enjoyable as possible. We take great pride in our ability to provide you with optimal dental care designed for your unique needs and desires.

The first step toward complete oral health is thorough examination and diagnosis. We want our patients to make informed choices by fully understanding any problems. Dr. Michael Miyamoto will review your dental needs with you at this appointment or at a second appointment to provide treatment consultation.

We look forward to meeting you. Your first appointment will be approximately one (1) hour. In order that we may respond to your unique needs and concerns, please complete the enclosed medical history and dental questionnaire and bring them to your appointment. Feel free to ask questions of our staff. We are all here to help you.

Sincerely,

Dr. Michael Miyamoto

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Registration Form

Please fill out accurately and completely. The confidential information requested is important for your treatment and insurance claim. If there is anything else we need to know, please tell us.

PATIENT INFORMATION

Patient Name: _____ Gender: _____ Date of Birth: _____

Home Address: _____

Mailing Address: _____

E-mail Address: _____ Best way to contact: _____

Phone: Home _____ Cell _____ Work _____

Employed By: _____ Occupation: _____

Best appt days and times: _____ Social Security #: _____

Dental Insurance and #: _____ Subscriber Name: _____

Secondary Dental Insurance and #: _____ Subscriber Name: _____

Relative/Friend **NOT** living with you: _____

Phone: _____ Relationship: _____

How were you referred to our office / How did you hear about us? _____

SPOUSE INFORMATION

Spouse Name: _____ Date of Birth: _____

Employed By: _____ Occupation: _____

Phone: Cell _____ Work _____

(OVER)

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MEDICAL INFORMATION

Patient's Name: _____ _____

Physician's Name (Medical): _____ Phone: _____

Please check any of the following that apply and list any medication that you are taking:

___ **PREMEDICATION (antibiotic) prescribed by MD** _____
___ abnormal bleeding: _____
___ anemia: _____
___ asthma: _____
___ birth control pills/patch: _____
___ blood thinners: _____
___ cancer: (date_____ type_____): _____
___ cholesterol: _____
___ diabetes: (type) 1 2 _____
___ drug addiction: _____
___ epilepsy: _____
___ frequent chest pain: _____
___ heart murmur/ mitral valve prolapse: _____
___ heart surgery: (date_____) _____
___ heart trouble/attack: (date_____) _____
___ stroke: (date_____) _____
___ hepatitis: (type) A B C _____
___ liver disease: _____
___ high/ low blood pressure: _____
___ HIV/AIDS: _____
___ joint replacement: (date_____ area_____) _____
___ kidney disease: _____
___ lupus: _____
___ migraine headaches: _____
___ osteoporosis: __ Fosamax __ Actonel _____
___ pacemaker/defibrillator: (date:_____) _____
___ pregnant/nursing: _____
___ thyroid: _____
___ tobacco: _____
___ tuberculosis: (date_____) _____
___ ***ALLERGIES:*** (please circle) penicillin aspirin local anesthesia latex
codeine (or other narcotics) metal/costume jewelry other _____
___ other physical conditions: _____
Please list other medications taking: _____
_____

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UPDATES

I, the undersigned, acknowledge that the information provided is correct to the best of my knowledge and that I have reviewed and updated as necessary:

Signed By: _____ Date: _____

Signed By: _____ Date: _____

Signed By: _____ Date: _____

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Child Registration Form

Please fill out accurately and completely. The confidential information requested is important for your treatment and insurance claim. If there is anything else we need to know, please tell us.

PATIENT INFORMATION

Patient Name: _____ Gender: _____ Date of Birth: _____

Home Address: _____

Mailing Address: _____

Phone: Home_____ Cell _____ Work_____

School:_____ City: _____

FATHER: _____

Employed By:_____ _____ _____

Phone: Home_____ Cell: _____ Work: _____

Dental Insurance: HDS _____ HMSA _____ Other _____

Father's Birthdate: _____ SS #_____ (if needed for insurance)

MOTHER: _____

Employed By:_____ _____ _____

Phone: Home: _____ Cell: _____ Work: _____

Dental Insurance: HDS _____ HMSA _____ Other _____

Mother's Birthdate:_____ SS #_____ (if needed for insurance)

RELATIVE OR CLOSE FRIEND:_____ _____ PHONE: _____

BEST TIME FOR APPOINTMENTS:__ _____ _____

WHO WILL PAY THIS ACCOUNT?___ _____ _____

(OVER)

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MEDICAL INFORMATION

Patient's Name: _____ _____

Physician's Name (Medical): _____ Phone: _____

Please check any of the following that apply and list any medication that you are taking:

___ abnormal bleeding: _____
___ anemia: _____
___ antibiotics for dental work: _____
___ asthma: _____
___ birth control pills/patch: _____
___ blood thinners: _____
___ cancer: (date_____ type_____): _____
___ cholesterol: _____
___ diabetes: (type) 1 2 _____
___ drug addiction: _____
___ epilepsy: _____
___ frequent chest pain: _____
___ heart murmur/ mitral valve prolapse: _____
___ heart surgery: (date_____) _____
___ heart trouble/attack: (date_____) _____
___ stroke: (date_____) _____
___ hepatitis: (type) A B C _____
___ liver disease: _____
___ high/ low blood pressure: _____
___ HIV/AIDS: _____
___ joint replacement: (date_____ area_____) _____
___ kidney disease: _____
___ lupus: _____
___ migraine headaches: _____
___ osteoporosis: __ Fosamax __ Actonel _____
___ pacemaker/defibrillator: (date:_____) _____
___ pregnant/nursing: _____
___ thyroid: _____
___ tobacco: _____
___ tuberculosis: (date_____) _____
___ ***ALLERGIES:*** (please circle) penicillin aspirin local anesthesia latex
codeine (or other narcotics) metal/costume jewelry other _____
___ other physical conditions: _____
Please list other medications taking: _____
_____

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I, the undersigned, acknowledge that the information provided is correct to the best of my knowledge and that I have reviewed and updated as necessary:

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Patient Questionnaire

Name _____ Date_____

Our practice is committed to providing each of our patients with individualized care consistent with their specific needs, wants, and values. By answering the following questions candidly, you will help us to better understand your dental concerns and expectations. Your answers are for our records only and will remain confidential.

1. Does dental treatment make you nervous? ❑No ❑Slightly ❑Moderately ❑Extremely

Have you ever had any serious trouble associated with previous dentistry? ❑Yes ❑No

How often do you use the following?

Toothbrush (manual or electric) _____

Dental floss _____

Other oral hygiene device _____

Do you have or have you ever had any of the following?

Orthodontic treatment (braces)?	❑Yes ❑No	Loose teeth?	❑Yes ❑No
Clicking/popping jaw?	❑Yes ❑No	Teeth sensitive to hot, cold, sweet?	❑Yes ❑No
Difficulty opening or closing jaw?	❑Yes ❑No	Teeth sensitive to chewing?	❑Yes ❑No
Clenching or grinding?	❑Yes ❑No	Bleeding or sore gums?	❑Yes ❑No
Shift or change in bite?	❑Yes ❑No	Unpleasant taste or bad breath?	❑Yes ❑No

The following best describes my attitude toward dental health:

❑I have always done what was recommended for my dental health.

❑I have not always done what dentists have recommended to me.

❑I rarely go to the dentist, not much interest in dental work.

Should I need treatment, my desires would be best described as:

❑wanting the best restoration possible that will be the most conservative and give the longest life.

❑wanting the least expensive restoration that will get me by for now.

Do you like the color of your teeth? ❑Yes ❑No

If NO, please describe_____

8. Do you consider your existing fillings or dental work as unattractive? ❑Yes ❑No

If YES, please describe_____

What would you like to change the most in the appearance of your teeth, your smile?

_____

_____

10. What are some questions about dentistry and your oral health that you have never had adequately answered?

_____

Signed By: _____ Date: _____