miyamoto
DENTAL DESIGN SUITE INC
Advanced Cosmetic & Restorative Dentistry · TMJ Disorders
1885 MAIN STREET · SUITE 203 · WAILUKU, HAWAII 96793 · PH 808-242-7007 · FX 808-242-8585
miyamotodds@hawaii.rr.com · mymauidentist.com
Michael R. Miyamoto, DDS

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 #:_____

1-Dental Insurance and #:_____ Subscriber Name:_____

2-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/PARTNER INFORMATION

Spouse/Partner 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:_____

☐ **PRE-MEDICATION (antibiotic) prescribed by Medical Doctor** _____
Preventative antibiotics due to history of heart surgery, joint replacement, and/or endocarditis.

- ☐ Acid reflux / GERD / peptic ulcers history
- ☐ Alzheimer's / dementia
- ☐ Anticoagulants / blood thinners (i.e. Aspirin, Plavix, Coumadin) / abnormal bleeding
- ☐ Artificial joints / joint replacement
- ☐ Asthma / emphysema / COPD
- ☐ Bipolar / schizophrenia
- ☐ Birth control pills / patch
- ☐ Diabetes Type ◯ 1 or ◯ 2
- ☐ Dry mouth
- ☐ Endocarditis history
- ☐ Epilepsy
- ☐ Headaches / migraines
- ☐ Heart attack (date: _____type: _____) / chest pain / angina
- ☐ Heart defect-congenital / disease
- ☐ Heart palpitations / arrhythmias / murmur / atrial fibrillation
- ☐ Heart surgery / implanted devices (i.e. pacemaker, defibrillator, stent, valve) (date: _____ type: _____)
- ☐ Hepatitis A, B, or C / jaundice
- ☐ High / low blood pressure
- ☐ HIV / AIDS
- ☐ Kidney disease / failure / dialysis
- ☐ Liver disease / cirrhosis
- ☐ Lupus / Sjogren's syndrome
- ☐ Mitral valve prolapse (date: _____type: _____)
- ☐ Osteoporosis / bisphosphonate medication (i.e. Fosamax, Actonel)
- ☐ Pregnant / possibly pregnant / nursing (due date: _____)
- ☐ Snoring / sleep apnea
- ☐ Stroke (date: _____)
- ☐ Temporomandibular joint disorder (TMD) / jaw joint pain and/or popping
- ☐ Thyroid
- ☐ Tobacco / substance abuse
- ☐ Tuberculosis

Other conditions:_____
_____
_____

Allergies, Sensitivities, Reactions

- ☐ Analgesics – codeine, aspirin, ibuprofen (list type)_____
- ☐ Anaphylaxis history
- ☐ Antibiotics allergy – Penicillin_____
- ☐ Latex allergy
- ☐ Metal or costume jewelry allergy

Other allergies:_____
_____
_____

History of Surgery *(Date and Type)*

- ☐ Cancer / treatment_____
- ☐ Surgeries_____
- ☐ Transplants (i.e. organs)_____

List other conditions and medications taken:_____
_____
_____

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ACKNOWLEDGEMENT / 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:_____

Signed By:_____ Date:_____

Signed By:_____ Date:_____

Signed By:_____ Date:_____

Signed By:_____ Date:_____

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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
2. Have you ever had any serious trouble associated with previous dentistry? ○ Yes ⊙ No
3. How often do you use the following?

   Toothbrush (manual or electric) _____

   Dental floss _____

   Other oral hygiene device _____
4. 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

5. 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.
6. 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.
7. 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_____
9. 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?

    _____