Kapahulu Dental Center
3358 Campbell Avenue Honolulu, HI 96815
Ph # : 808-734-8820 Fax # : 808-732-6006

All information will be kept strictly confidential!

Patient Personal Information

Last, First, M.I.:_____
Address: _____
City, State, Zip: _____
Email: _____
SSN: _____

Birth Date: _____ Age: _____
Marital Status: _____ Sex: Male / Female
Home #: _____ Work #: _____
Cell #: _____ Drive Lic: _____
Student: Yes / No School Name: _____

Person responsible/guarantor for paying bills

Last, First: _____
Address: _____
City, State, Zip: _____
Email: _____

Birth Date: _____ Age: _____
Marital Status: _____ Sex: Male / Female
Home #: _____ Work #: _____
Cell #: _____ Drive Lic: _____

Do you have Primary Dental Insurance? __ Yes __ No
Group No: _____
Name Insurance:_____
Name Employer: _____
Name Subscriber: _____
Subscriber Address: _____
City, State, Zip: _____
Relationship to Patient: _____
Subscriber ID: _____

Do you have Secondary Dental Insurance? __ Yes __ No
Group No: _____
Name Insurance:_____
Name Employer: _____
Name Subscriber: _____
Subscriber Address: _____
City, State, Zip: _____
Relationship to Patient: _____
Subscriber ID: _____

Patient Medical Information

Allergic To:
❍No Known Allergies
❍Aspirin
❍Barbiturates
❍Sleeping Pills
❍Codeine
❍Erythromycin
❍Iodine
❍Latex
❍Rubber
❍Local Anesthetics
❍Metals
❍No Epinephrine
❍Penicillin
❍Prior Hepatitis
❍Sulfa Drugs
❍Other
_____

Check, if applicable (Do you have or have you had any of the following?)
❍No Change Since Last Recorded
❍No Known Concerns or Issues
❍AIDS/HIV Infection
❍Alcohol
❍Drug Abuse
❍Anemia
❍Leukemia
❍Ankles Swell
❍Anorexia / Bulimia
❍Arthritis
❍Asthma / Hay Fever
❍Blood Clotting Problems
❍Blood Transfusion
❍Bronchitis
❍Cancer / Tumor or Growth
❍Cardiac Pacemaker
❍Chest Pain Upon Exertion
❍Color Blindness
❍Contact Lenses
❍Damaged Heart Valve
❍Diabetes
❍Emphysema
❍Environmental Allergies
❍Epilepsy
❍Fainting Spells / Seizures
❍Fever Blisters / Herpes
❍Frequent Headaches
❍Frequently Dry Mouth / Sjogren
❍Gall Bladder Trouble
❍Heart Attack / Stroke
❍Heart Disease / Angina
❍Heart Murmur
❍Hepatitis / Jaundice
❍High Blood Pressure
❍Hives / Skin Rash
❍Joint Replacement
❍Kidney / Bladder Trouble
❍Liver Disease
❍Low Blood Pressure
❍Mental Health Problems
❍Mitral Valve Prolapse
❍Persistent Diarrhea
❍PREMEDICATE
❍Rheumatic Fever
❍Rheumatic Heart Disease
❍Sexually Transmitted Disease
❍Shortness of Breath
❍Sinus Trouble
❍Stomach Ulcers
❍Thyroid Problems
❍Tuberculosis
❍Unusual Weight Loss
❍Urinate Frequently
❍**Other:**
_____

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Dental Questionnaire

Name of previous Dentist _____ Office Phone _____

Date of your last cleaning _____ Last exam date _____

Date of your last full series x-rays _____

Date of last cavity detection (bitewing) x-rays _____

Do your gums bleed while brushing or flossing ? _____

Are your teeth sensitive to hot, cold or sweets ? _____

Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth ? _____

Have you ever had burning of the tongue or cracking of the corners of your mouth ? _____

Do you chew/smoke tobacco in any form ? _____

Have you had any head, neck or jaw injuries ? _____

Do you notice popping, clicking or soreness of the jaws or points just in front of the ears ? _____

Do you clench or grind your teeth ? _____

Have you ever had orthodontic treatment ? _____ If Yes, date of placement _____

Do you wear dentures or partials ? Yes / No If Yes, date of placement of dentures ? _____

Are you happy with your dentures ? _____

Are you having any specific problems with your teeth, gums, or mouth at this time ? _____

Are you happy with your smile ? _____

Do you have problems with teeth/fillings breaking ? _____

Do you regularly use dental floss ? _____

Do you have ever been told you have Pyorrhea ? _____

Do you have difficulty in opening your mouth widely ? _____

Do you have an unpleasant taste or odor in your teeth/mouth ? _____

Does food catch between your teeth ? _____

Do you want to learn to control your dental disease and retain your teeth ? _____

Additional Comments _____

_____

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Medical Questionnaire

Family Physician _____Phone _____

Are you currently under care of a Physician ? Yes / No

If Yes, what is the condition being treated ? _____

Have you had any serious illness, operation or been hospitalized within the past 5 years ? _____

If Yes, what illness or problem ? _____

Are you currently taking any medication ? Yes / No If Yes, what ? _____

Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast)

_____

Have you ever taken the diet control drug Fen-Phen ? _____

Do you use alcoholic beverages ? Yes / No

Do you smoke ? Yes / No

Women Only

Are you pregnant? Yes / No If Yes, what is your due date ? _____

Do you have menstrual period problems ? _____

Are you currently nursing ? _____

Are you on hormone replacement therapy ? _____

Are you on birth control pills / fertility drugs ? _____

Additional Comments

Any Disease, Condition or Problem not Listed ? Yes / No Please list _____

By signing below, I certify that all of the above information is true to the best of my knowledge.

_____ _____

Patient/Guardian Signature **Date**