PERIODONTAL SPECIALISTS OF HAWAII

Ryan H. Yim, D.D.S., L.L.C.

Edmund A. Cassella, D.M.D., L.L.C. ~ Allison P. Tran, D.D.S., L.L.C.

New Patient Information Form

Patient's Name: ____ Sex: ☐ M ☐ F

Title: Dr., Mr., Mrs., Ms., etc. First Middle Last

How do you wish to be addressed? ______________________ Date of Birth:_____/_____/_____

Home Address: ____

Street City ZipCode

Mailing address:______________________________ Marital Status: ___________

(if different from above) Street City ZipCode

Home Phone: ______________ Business Phone: ______________ Ext:_______ Cell/Pager:______________

Email:______________________________ **Do you check your email daily?** ☐ Yes ☐ No

May we call you to confirm your appointments? ☐Yes ☐No **May we leave detailed messages**? ☐Yes ☐No

Best point of contact to confirm: ☐ home ☐ business ☐ email ☐ cell/pager

Employer: ______________________ How Long? ________ Social Security #:________________

Spouse/Parent/Guardian: ______________________________ Date of Birth: _____/_____/_____

Spouse employed by: ______________________ Social Security #:________________

Whom may we thank for referring you? ______________________ General Dentist:________________

Emergency Contact: ________________ Phone: ________________ Relationship: ____________

Insurance Information

Do you have Dental Insurance? ☐Yes ☐No Kaiser Medical ID #____________________

Primary Insurance: HDS HMSA HMAA United Concordia Other:____________________

Subscriber Name:______________ Subscriber#:______________ Group/Plan#: ____________

Effective Date: ____________ Periodontal %: ________ Max Coverage: __________ Calendar Year: ________

Secondary Insurance: HDS HMSA HMAA United Concordia Other:____________________

Subscriber Name:______________ Subscriber #:______________ Group/Plan #: ____________

Effective Date: ____________ Periodontal %: ________ Max Coverage: __________ Calendar Year: ________

Dental History

Are you having pain or discomfort at this time? Yes No

Have you ever received periodontal treatment? Yes No

If so, what year?______________

Have you ever been to a periodontist? Yes No

Do your gums bleed? Yes No

Are you aware of a bad odor or taste in your mouth? Yes No

Does food wedge between your teeth? Yes No

Have you had any gum boils or gum swelling? Yes No

Do you have frequent "cold sores"? Yes No

Do you have difficulty chewing your food? Yes No

Have you ever had difficulty with a dental procedure? Yes No

Have you ever had problems with extractions? Yes No

Have you ever had orthodontic treatment (braces)? Yes No

Are spaces developing between your teeth? Yes No

Have any members of your family lost all their teeth? Yes No

Are your teeth sensitive to hot, cold or sweets? Yes No

Do any of your teeth feel loose? Yes No

Do you have pain in the jaw joints (TMJ)? Yes No

Do you grind or clench your teeth? Yes No

Have you noticed your bite changing? Yes No

Has anyone shown you how to clean your teeth? Yes No

Do you clean your teeth before bedtime? Yes No

Are you satisfied with the appearance of your teeth? Yes No

Please check any of the following items you are currently using:

___Dental Floss ___Floss holder ___Peroxide ___Proxabrush/Interdental brush ___Sonicare electric toothbrush

___Stimudent ___ Rubber tip ___Toothpicks/Perio aid ___Tartar control toothpaste ___ Oral-B electric toothbrush

___Baking soda ___Mouthwash ___Water spray device ___ Non-Fluoride Toothpaste ___ Battery-Operated Toothbrush

Health History

Physician's Name: ______________________________ Specialty: ___________________ Phone #: _________________

Physicians Address: ____

Date of last physical exam: ________________ Have you been hospitalized within the past 2 years? __________________

How would you describe your present health? EXCELLENT____ GOOD____ FAIR____ POOR____

Periodontal disease and its treatment can be affected by your medical condition and any medications you may be taking, so please provide the following information as accurately as possible. **Please check if you have or ever had any of the following:**

Condition		Condition		Condition	
Allergies to any Medicine	☐ Yes ☐ No	Angina Pectoris/Chest Pain	☐ Yes ☐ No	AIDS or HIV Positive	☐ Yes ☐ No
If Yes, type:______________________		Anemia or Bleeding Disorders	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
____________________________		Drug reactions	☐Yes ☐ No	Jaundice	☐ Yes ☐ No
Allergies to Anesthetics	☐ Yes ☐ No	Alcoholism	☐ Yes ☐ No	Hives or Skin Rash	☐ Yes ☐ No
Asthma or Hay Fever	☐ Yes ☐ No	Drug Abuse	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Other Allergies	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No
If Yes, type: ______________________		Sleeping problems	☐ Yes ☐ No	Vision Problems	☐ Yes ☐ No
Herpes/ Cold Sores	☐ Yes ☐ No	Nervous Problems, Stress	☐ Yes ☐ No	Contact Lenses	☐ Yes ☐ No
Headaches (Frequent)	☐ Yes ☐ No	Stomach or Duodenal Ulcers	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Rapid Weight Loss	☐ Yes ☐ No	Emphysema or Chronic Bronchitis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Smoking Habit	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No	Surgery	☐ Yes ☐ No
Lung Disease	☐ Yes ☐ No	Hip or Joint Replacement	☐ Yes ☐ No	Swelling in Ankles	☐ Yes ☐ No
Shortness of Breath	☐ Yes ☐ No	Cancer or Abnormal Growth	☐ Yes ☐ No	Gout	☐ Yes ☐ No
Arteriosclerosis	☐ Yes ☐ No	If Yes, Type?___________________________		Scarlet Fever	☐ Yes ☐ No
Osteosporosis	☐ Yes ☐ No	Medications?___________________________		Kidney Disease	☐ Yes ☐ No
Medications?______________________		Radiation or Chemotherapy	☐ Yes ☐ No	Diabetes	☐ Yes ☐No
Rheumatic Fever	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	If Yes, Medication?	☐ Yes ☐ No
Rheumatic Heart Disease	☐ Yes ☐ No	Heart Defects or Problems	☐ Yes ☐ No	Type:_________________________	
Epilepsy	☐ Yes ☐ No	Artificial Heart Valve	☐ Yes ☐ No	HbA1c (A1C): _________________	
Hepatitis:	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No		
___ Type A Year: _________		If Yes, Medication?	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No
___ Type B Year: _________		Type: ____________________________		If Yes, Medication?	☐ Yes ☐ No
___ Type C Year:__________		Heart Murmur or Valve Problem	☐ Yes ☐ No	Type:_______________________	

Do you take any Anti-Coagulants to include **Plavix, Warfarin, Aspirin, Vitamin E, Gingko-Biloba**? ☐ Yes ☐ No, If Yes, Type: ___________________

If **Aspirin or Prescription Anti-Coagulant**, Who is the Prescribing Physician? _______________________Office Location:_________________________

Have you ever taken a **Bisphosphonate** for osteosporosis or cancer? (Actonel, Boniva, Fosomax, Zometa, Reclast, Xgeva or Prolia) ____________

If Yes, Type: ______________________________ How was it administered? (Oral pills, IV, IM) ____

Do you take any kind of medicines or drugs, including **Vitamins, Hormones, Antacids** or **Birth Control Pills**?________________

If you answered **YES**, please list:____

____

If you use **tobacco** products, please list type, brand and frequency of use: ____

FEMALES—Are you pregnant, planning pregnancy or breast-feeding? ____

Please indicate any other conditions or medical concerns you may have: ____

____

Do you **pre-medicate** (take antibiotics that your physician has prescribed for either a **heart condition/hip or joint replacement/rheumatic fever**)?_______

If yes, list **Medication and Dosage**: ____

Release

I authorize Dr. Yim or Dr. Cassella or Dr. Tran to perform diagnostic procedures and treatment as may be necessary for proper dental and periodontal care. I consent to have clinical photographs taken for identification, treatment and teaching purposes. I authorize release of any information concerning my health and dental care and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also authorize release of any information to another dentist or physician.

I authorize payment of my insurance benefits directly to Dr. Yim or Dr. Cassella or Dr. Tran and I understand that their staff will do everything possible to help me obtain benefits to which I am entitled. However, I fully understand that any fees incurred are ultimately my responsibility.

To the best of my knowledge, all of the answers are true and correct. If ever any changes in my health, or if my medicines change, I will inform Dr. Yim or Dr. Cassella or Dr Tran or their staff at the next appointment without fail.

Patient's Signature: ____ **Date:** ____________

Name: ____ **Signature:** _______________________________

Person signing authorizing treatment of a minor **Relationship to Patient:**____

Thank you for your effort in completing this form and all accompanying forms!

Office Use only: This Form has been reviewed by Dr. Ryan Yim or Dr. Edmund A. Cassella or Dr. Allison Tran

____ ________________________

Dr. Ryan Yim or Dr. Edmund Cassella or Dr. Allison Tran Signature Date