Malia K. Kamisugi DDS MSD
"Keeping Hawaii Smiling"

Patient's Name_____Age____Sex____Birth Date_____
Home Address_____City _____Zip_____
Home #_____School_____Grade_____
Cell # _____Email Address_____

Father's Name _____Cell #_____ Work #_____
Email address_____
Occupation_____Employed by _____
Mother's Name _____Cell #_____ Work #_____
Email address_____
Occupation _____Employed by _____

Parent's Marital Status Single____ Married____ Separated____ Divorced____ Widowed____
Patient lives with Parents___ Father___ Mother__ Guardian___ Guardians Name_____
Name and Ages of Other Children in the Family _____
Has anyone in your immediate family had orthodontic treatment with us? _____
If so, who? _____
Is there anyone else that would like to be seen by us today? _____

Referred by _____**Relationship**_____
Dentist's Name_____Location_____
Date of last dental cleaning_____Next cleaning due_____

WHO WILL BE FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT?
Name_____Relationship_____ Telephone #_____
Home address_____Business #_____
Email address _____

INSURANCE INFORMATION
Do you have Dental Insurance? Yes___ No___ Carrier_____
Subscriber Name _____
Subscriber ID/SS# _____ Subscriber Date of Birth _____

MEDICAL HISTORY

Is the patient in good health? Yes___No___
Has the patient ever had any serious illness? Yes___No___
Has the patient ever been hospitalized or had any major operations Yes___No___
If so, please explain _____
Is the patient under the care of a physician? Yes___No___
Physician's Name_____Phone# _____
Condition being treated_____

Has the patient been treated for any of the following? (please circle)

AIDS	Drug Reaction	Hepatitis	Pneumonia
Allergies	Endocrine	Herpes	Rheumatic Fever
Anemia	Epilepsy	HIV	Tuberculosis
Asthma	Fainting/Dizziness	Kidney Trouble	Venereal Disease
Bone Disorders	Heart Problems	Leukemia	Diabetes
Hemophilia	Liver Trouble	High Blood Pressure	

Are there any medical conditions that would have any effect on orthodontic treatment or that we should know about? Yes___No___
If yes, describe_____

Does the patient have glaucoma? Yes _____ No _____

Does the patient have a tendency for colds___sore throats___canker sores___or ear infections?___
Have tonsils and adenoids been removed? Yes____ No____ At what age?_____
List any drugs or medications now being taken:_____
Please give reasons: _____

The above information is complete and true to my knowledge.

Signature_____ **Date** _____

Patient Name _____