Malia Pietsch Kamisugi DDS MSD
"Keeping Hawaii Smiling"

Patient's Name_____Age____Sex____Birth Date_____
Home Address _____City _____Zip _____
Cell # _____ Home #_____ Business #_____
Email Address _____ Best way to contact you_____

Occupation_____
Employed by_____How long?_____

Marital Status Single☐ Married☐ Separated☐ Divorced☐ Widowed☐
Spouse's Name (if married)_____ Spouse's Cell #_____
Name and ages of children in the family (if any) _____
Has anyone in your immediate family had orthodontic treatment with us? _____

Referred by _____Relationship to you_____
Dentist's Name_____Location_____
Last dental cleaning: _____Date of next cleaning:_____

WHO WILL BE FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT?_____
Name_____Relationship_____Telephone # _____
Home address_____ Business # _____

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 _____