NORMAN H. NISHIKAWA, D.D.S.
Forest Office Park
14655 Bel-Red Road, #F103
Bellevue, Washington 98007
Telephone: (425) 641-1902

Today's Date ____/____/____

PATIENT INFORMATION

Patient's Last Name	First	Middle		Preferred Name / Nickname
Birthdate / /	Social Security Number	❑ Male ❑ Female	❑ Mr. ❑ Ms. ❑ Dr. ❑ Mrs.	❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced
Street Address				Home Phone ( )
City		State	Zip	Cell Phone ( )
Email Address	Occupation	Employer		Work Phone ( )

How did you hear about our office? ❑ Family ❑ Friend/ Coworker ❑ Insurance Directory ❑ Internet/ Email ❑ Flyer/ Direct Mailing ❑ Outdoor Signs ❑ Marketing Representative

Whom may we thank for referring you to your practice?	Other Family Members Seen Here

INSURANCE (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill			Relationship to Patient
Birthdate / /	Social Security Number	Email Address	Home Phone ( )
Street Address (if different)			Cell Phone ( )
City	State	Zip	Work Phone ( )
Primary Insurance Company	Subscriber's Name		Group #
Secondary Insurance Company	Subscriber's Name		Group #

DENTAL HISTORY

Reason for Today's Visit ❑ Routine Exam/Cleaning ❑ Pain/Emergency ❑ Consultation ❑ Other_____

Are you in pain? ❑ Yes ❑ No If yes, how long?_____

Please indicate any of the following problems:

- ❑ Red, swollen or bleeding gums
- ❑ Sensitive teeth or gums
- ❑ Sensitive to heat
- ❑ Sensitive to cold
- ❑ Broken/chipped tooth
- ❑ Lost/broken filling(s)
- ❑ Teeth grinding
- ❑ Ringing in ear
- ❑ Bad breath
- ❑ Stained teeth
- ❑ Blisters/sores in or around the mouth
- ❑ Discomfort, clicking or popping in jaw

Do you require pre-medication (antibiotics prior to dental treatment)? ❑ Yes ❑ No ❑ Don't Know

Previous Dentist	City, State	Phone
Last Dental Visit	Last X-Rays	

Reasons for changing dentist: ❑ Moved ❑ Changed insurance ❑ Not satisfied with previous dentist ❑ Referred to our office ❑ Other_____

MEDICAL HISTORY

Name of Primary Physician	Physician's Phone ( )

Please indicate if you have or ever had any of the following diseases or medical conditions:

- ❑ Heart Attack / Stroke
- ❑ Heart Surgery / Pacemaker
- ❑ Heart Murmur
- ❑ Rheumatic Fever
- ❑ Mitral Valve Prolapse
- ❑ Artificial Valves
- ❑ Heart Disease
- ❑ Congenital Heart Defect
- ❑ Chest Pains
- ❑ Scarlet Fever
- ❑ Kidney Problems
- ❑ Liver Problems
- ❑ Respiratory Problems
- ❑ Sinus Problems
- ❑ Stomach Problems / Ulcers
- ❑ Psychiatric Problems
- ❑ Venereal Disease
- ❑ Alcohol / Drug Abuse
- ❑ Tuberculosis (TB)
- ❑ Jaw Problems (TMJ / TMD)
- ❑ Cancer / Tumor
- ❑ Chemotherapy / Radiation
- ❑ Hepatitis
- ❑ HIV+ / AIDS
- ❑ Arthritis / Rheumatism
- ❑ Artificial Bones / Joints
- ❑ Emphysema
- ❑ Fainting / Seizures / Epilepsy
- ❑ Severe/Frequent Headaches
- ❑ Frequent Neck Pain
- ❑ Shingles
- ❑ Asthma
- ❑ Difficulty Breathing
- ❑ Diabetes
- ❑ Anemia
- ❑ Low Blood Pressure
- ❑ High Blood Pressure
- ❑ Bleeding Problems
- ❑ Glaucoma
- ❑ Back Problems
- ❑ Other Medical Conditions_____

Please list all medications you are currently taking:

Are you allergic to any of the following?

- ❑ Aspirin
- ❑ Ibuprofen
- ❑ Sulfa Drugs
- ❑ Penicillin
- ❑ Codeine
- ❑ Latex
- ❑ Local Anesthetics
- ❑ Other Medications_____

Do you use tobacco?	❑ Yes	❑ No	If yes, what form?_____	How much?_____	How long?_____

For Women: Are you pregnant? ❑ Yes ❑ No If yes, how long?_____ Are you nursing? ❑ Yes ❑ No

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)		Relationship to Patient
Home Phone ( )	Cell Phone ( )	Work Phone ( )

- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 60 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize and give consent to perform any necessary or advisable services during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

X _____

PATIENT/GUARDIAN SIGNATURE DATE