No.E-004

DIO

Dental International Orthodontic Office

Fumino,DDS.MS

TEL:03-3538-2113

# PERSONAL INFORMATION

______/______/ 20______

Please fill out both sides of this form completely and bring it with you to your consultaion appointment.

## *PATIENT INFORMATION*

Name : Last ________________ First ________________ Middle ________________

Nickname : ________________ Sex : ______ Birthday : ____/____/____ Age :______

Address : ________________________________ Zip :_____-_____

Phone : (_____)______-______ Fax : (_____)______-______

Email Address : ________________________

Office or School : ________________________

Address : ________________________________ Zip :_____-_____

Phone : (_____)______-______

Whom may we thank for referring you to our office? : ________________________

What are your dentist's concerns? : ________________________

Have you ever seen an Orthodontist before? Yes / No

If Yes ask : Did he explain your/your child problem to you? Yes / No

If Yes ask : Explanation ________________________

How did you/your child feel about the explanation? : ________________________

If No ask : What are your concerns? ________________________

Is there other family that you would like examined? Yes / No

## *RESPONSIBLE PARTY INFORMATION*

Name : Last ________________ First ________________ Middle ________________

Address : ________________________________ Zip :_____-_____

Phone : (_____)______-______ Fax : (_____)______-______

Office : ________________________

Address : ________________________________ Zip :_____-_____

Phone : (_____)______-______

## *INSURANCE INFORMATION*

Insured's Name : ________________________ Insured Soc.Sec.# : ____________

Employer : ________________________

Employer Address : ________________________

Insurance Co. : ________________________ Group No. : ______ Local No. : ______

Insurance Co. Address : ________________________

Insurance Co. Phone : ________________ Insurance Co. Fax : ________________

Do you have dual coverage? Yes / No If yes : ________________________

## Do you

| | | If yes, |
|---|---|---|
| have any health problems (current or past) | Yes / No | ______________________ |
| take any medications (current or past) | Yes / No | ______________________ |
| currently see a physician for a medical condition | Yes / No | ______________________ |
| have allergies (itching,rash,swelling,sensitivity) to anything | Yes / No | ______________________ |
| have a history of any illnesses or hospitalizations | Yes / No | ______________________ |
| have a history of any surgery or major medical problems | Yes / No | ______________________ |
| wear contact lenses or any artificial aid | Yes / No | ______________________ |
| use drugs,alcohol or tobacco | Yes / No | ______________________ |
| have trouble breathing through the nose (mouth breather) | Yes / No | ______________________ |
| have a tendency for ear infections or noise in the jaw joint | Yes / No | ______________________ |
| have any pain or clicking in the jaw joint or head/neck regions | Yes / No | ______________________ |
| have any habits (thumb sucking,finger biting, tongue thrusting) | Yes / No | ______________________ |
| experience frequent headaches or head/neck pain | Yes / No | ______________________ |
| play any wind/reed instruments or the violin | Yes / No | ______________________ |
| have negative reactions or experiences to any type of dental work | Yes / No | ______________________ |
| need to take medications before dental work because of a heart or valve condition | Yes / No | ______________________ |

## Have you ever had

| | | | |
|---|---|---|---|
| heart trouble, congential heart lesions | Yes / No | diabetes or a family history of same | Yes / No |
| heart murmur, heart pacer | Yes / No | excessive chronic thirst | Yes / No |
| high or low blood pressure | Yes / No | thyroid disorders or family history | Yes / No |
| rheumatic fever, heart valve problems | Yes / No | endocrine disturbances | Yes / No |
| arteriosclerosis or stroke | Yes / No | anemia, blood diseases | Yes / No |
| chest pains on mild exertion | Yes / No | bleeding disorders, prolonged bleeding | Yes / No |
| shortness of breath on mind exertion | Yes / No | arthritis, sore or swollen joints | Yes / No |
| kidney disease or problems | Yes / No | tuberculosis, chronic or frequent cough | Yes / No |
| excessively swollen ankles or tissues | Yes / No | mononucleosis or other viral diseases | Yes / No |
| anorexia,bulimia | Yes / No | HIV virus or AIDS | Yes / No |
| venereal disease | Yes / No | ulcers, internal bleeding | Yes / No |
| scarlet fever | Yes / No | emphysema, breathing problems | Yes / No |
| liver disease | Yes / No | asthma, respiratory prolems | Yes / No |
| hepatitis, jaundice, liver problems | Yes / No | radiation treatment, chemotherapy | Yes / No |
| hearing problems, ringing in the ears | Yes / No | malignancies, tumors or growths | Yes / No |
| cold sores, herpetic lesions, cankers | Yes / No | epilepsy or seizures | Yes / No |
| skin rash, lesion, hives, fever blisters | Yes / No | hyperactivity, nervousness | Yes / No |
| prostate disorders | Yes / No | fainting, dizziness, unconsciousness | Yes / No |
| glaucoma, cataracts | Yes / No | chronic exhaustion or fatigue | Yes / No |
| sudden weight change | Yes / No | chronic nervousness, high stress | Yes / No |
| trauma to face, chin or jaw | Yes / No | chronic unhappiness or depression | Yes / No |
| frequent chronic headaches | Yes / No | emotional problems or tension | Yes / No |
| blood transfusion, | Yes / No | psychiatric treatment | Yes / No |

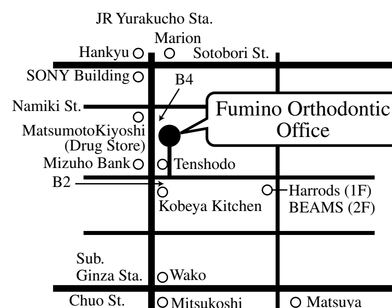
## For female patient, are you now

☐ pregnant ☐ presently in menopause ☐ taking birth control ☐ past menopause

**Thank you for your coorporation.**


DIO *Fumino Orthodontic Office*

Open: 11:00--13:30 14:30--19:00
Closed: Mondays, Sundays & holidays
Phone: 03-3538-2113
Fax: 03-3538-2114
Address: 3F Motoki N4 Bldg,
4-3-10 Ginza, Chuo-ku, Tokyo
1min. walk from Sub. Ginza Station. (B2, B4)
3min. walk from Sub. Ginza 1cho-me Station.
3min. walk from Sub. Higashi Ginza Station.
5min. walk from JR. Yurakucho Station.


(Patent pending)