Laurence S. Masuoka, D.M.D.
Marleen M. Masuoka, D.D.S.

By Appointment 916.966.9900

Submit

GETTING TO KNOW YOU

Name: _____ Date: _____
First Middle Last

Address: _____
Street or P.O. Box City State Zip Code

Phone: _____
Home Work

E-mail: _____

Birthdate: _____ Social Security Number: _____
Month Day Year

Occupation: _____ Employer: _____

Whom may we thank for referring you? _____

Person to contact for emergency: _____ Phone: _____

When was your last dental visit? _____ Date of last complete X-rays: _____

Name of Previous Dentist: _____

INSURANCE INFORMATION

Insured person's full name: _____

Work Phone: _____ Social Security Number: _____

Insurance Company: _____

Relationship to Patient: _____ Date of Birth: _____

Group or Union Name: _____

Group or Local Number: _____

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Fair Oaks, CA 95628

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info@drmasuoka.com

MEDICAL HISTORY

1. Are you having any dental problems at this time? ◯ Yes ◯ No
2. Do your gums bleed at any time? ◯ Yes ◯ No
3. Do you feel nervous about having dental treatment? ◯ Yes ◯ No
4. Have you ever had a bad experience in the dental office? ◯ Yes ◯ No
5. Have you been under medical care or hospitalized during the past two years? ◯ Yes ◯ No

   If yes, for what reason? _____
6. Are you allergic to any drugs or medication (itching, rash, swelling)? ◯ Yes ◯ No
7. Have you ever been made sick by penicillin, aspirin, codeine or any drugs? ◯ Yes ◯ No
8. Have you ever had any excessive bleeding requiring special treatment? ◯ Yes ◯ No
9. Women: Are you pregnant? If yes, when are you due? ◯ Yes ◯ No

   Are you taking birth control pills? ◯ Yes ◯ No
10. Check any of the following which you have had or have at the present:

☐ Heart Disease or Attack	☐ Artificial Joint	☐ Thyroid Disease	☐ Liver Disease
☐ Angina (chest pain)	☐ Anemia	☐ Radiation therapy	☐ Yellow Jaundice
☐ High Blood Pressure	☐ Ulcers	☐ Chemotherapy	☐ Blood Transfusion
☐ Heart Murmur	☐ Shortness of Breath	☐ Glaucoma	☐ Diabetes
☐ Rheumatic Fever	☐ Emphysema	☐ Arthritis	☐ Hemophilia
☐ Congenital Heart Problems	☐ Tuberculosis (TB)	☐ Rheumatism	☐ Venereal Disease
☐ Stroke	☐ Asthma	☐ Cortisone Medication	☐ Epilepsy or Seizures
☐ Artificial Heart Valve	☐ Sinus Trouble	☐ HIV Positive	☐ Fainting or Dizzy Spells
☐ Heart Pacemaker	☐ Allergies or Hives	☐ Hepatitis A (Infectious)	☐ Psychiatric Treatment
☐ Heart Surgery	☐ Pain in the Jaw Joints	☐ Hepatitis B (Serum)	☐ Kidney Trouble

11. Have you been using recreational drugs? ◯ Yes ◯ No
12. Do you ever have chest pain or shortness of breath from walking? ◯ Yes ◯ No
13. Has your physician ever said you have cancer or a tumor? ◯ Yes ◯ No
14. Are you on a special diet under a physicians care? ◯ Yes ◯ No
15. Have you ever taken a Bisphosphonate medication? ◯ Yes ◯ No

16. Please list any disease or condition not covered above. _____
17. If you smoke or drink, how much each day? _____
18. Please list all the medications you are taking at this time (including fluoride). _____

_____

19. How do you feel about the appearance of your teeth? _____
20. If you could change anything about your smile, what would you change? _____

To the best of my knowledge, I have answered every question completely and accurately.
I will inform my dentist of any change in my health and/or medication.

Patient Signature _____ Date _____

History Reviewed _____ Date _____ History Reviewed _____ Date _____

History Reviewed _____ Date _____ History Reviewed _____ Date _____