CURTIS N. KAMISUGI, DDS, MSD
Specialist in Orthodontics
Patient Registration Form

Date: _____/_____/_____

PATIENT INFORMATION (Please Print)

Name: ________________________ Age: ____ Date of Birth: ___/___/___ Sex: M / F
Home Address: ________________________ City: ____________ State: ______ Zip: ______
Home Phone: ____________ Business Phone: ____________ Cell Phone: ____________
Occupation/School: ________________________ Employed by/Grade: ____________
Business Address: ________________________ City: ____________ State: ______ Zip: ______
Referred by: ________________________ Dentist: ____________ Physician: ____________
Spouse's Name: ________________________ Siblings: ____________

RESPONSIBLE PARTY

Father's/Guardian's Name: ________________________ Date of Birth: ___/___/___ SS#: ____________
Home Address: ________________________ City: ____________ State: ______ Zip: ______
Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

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Mother's/Guardian's Name: ________________________ Date of Birth: ___/___/___ SS#: ____________
Home Address: ________________________ City: ____________ State: ______ Zip: ______
Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Child resides with: ________________________

MEDICAL HISTORY

Do you have or have you ever had any of the following conditions?

_____	High blood pressure	_____	Cold sores/Canker sores	_____	Bleeding Problems
_____	Heart murmur/Rheumatic Fever	_____	Thyroid Disease	_____	Hemophilia
_____	Stroke	_____	Arthritis	_____	Stomach ulcers/Gastritis
_____	Emphysema	_____	Diabetes	_____	Cancer
_____	Sinusitis	_____	Epilepsy	_____	Frequent headaches
_____	Hepatitis	_____	Kidney infection disease	_____	Allergies/hives
_____	Venereal disease	_____	Anemia	_____	Latex sensitivity

	Yes	No
Have you ever been hospitalized/had major surgery?	____	____
Please explain		
Are you currently taking any medications?	____	____
Please list		
Have you ever tested positive for?		
Tuberculosis (TB)	____	____
Human Immune Deficiency Virus (HIV)	____	____
Have you ever had a blood transfusion?	____	____
Do you have any implants or artificial prostheses?	____	____
Do you currently or have you ever been under psychiatric care/counseling?	____	____
Do you smoke/chew tobacco?	____	____

DENTAL HISTORY

	Yes	No
Has there been any injury to your face, mouth or teeth?	____	____
Do your jaws pop or click?	____	____
Do you have any difficulty in opening/closing your mouth?	____	____
Have you ever sucked thumb or fingers?	____	____
Until what age?		
Have you ever been informed of missing or extra permanent teeth?	____	____
Do you pre-medicate prior to any dental procedures?	____	____
Are you currently or have you ever been treated for periodontal (gum) disease?	____	____
You have ever had an orthodontic examination or treatment?	____	____
When was your last dental check-up and cleaning?	____	____
Is this visit due to a work related injury or accident?	____	____

(Note: Dr. Kamisugi does not participate/accept Workman's Comp. Cases)

DENTAL INSURANCE INFORMATION (Please present dental insurance card)

Primary

☐ HDS ☐ HMSA ☐ TRI-CARE ☐ OTHER: ______________________________

Subscriber's Name: ____

Social Security No: _________/_________/_________ Date of Birth: ______/______/______

Employer: ____________________________________ Employer's Phone No: ______________

Membership No: _______________________________ Group No: ______________________

Dental Code: ______________________

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Secondary

☐ HDS ☐ HMSA ☐ TRI-CARE ☐ OTHER: ______________________________

Subscriber's Name: ____

Social Security No: _________/_________/_________ Date of Birth: ______/______/______

Employer: ____________________________________ Employer's Phone No: ______________

Membership No: _______________________________ Group No: ______________________

Dental Code: ______________________

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

SIGNATURE ON FILE

I authorize use of this form, and information on all my insurance submissions.
I authorize release of information to my insurance carriers to process my claims.
I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.
I authorize my insurance benefits to be paid directly to my doctor.
I understand I am financially responsible for any balance.
I permit a copy of this authorization to be used in place of the original.

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status I will so inform this practice.

*Name (Please Print)*______________________________ *Signature:* ______________________________ *Date:* ___/___/___
(Parent or guardian)