Patient Information Form
Kyle Yamamoto, D.D.S., M.D., M.S., Inc.
22410 Hawthorne Boulevard Suite 3
Torrance, California 90505

Date:_____

Patient:_____Birthday:_____Age:_____Sex:_____

Address:_____City:_____Zip:_____

Primary Phone:cell/home/work ( )_____ Secondary Phone:cell/home/work( )_____

Marital Status: (circle one) Single/Married/Divorced/Other_____ Social Security #:_____

Employer:_____

Address:_____City:_____Zip:_____

If patient is a student, name of school:_____City/State:_____

Primary Insurance Circle: Dental/Medical
Name of Subscriber:_____Birthday:_____Social Security #:_____

Relationship to patient:_____ Employer:_____

Employer Address:_____City:_____Zip:_____

Insurance Company:_____ Group #:_____ ID#:_____

Address:_____City/State:_____Zip:_____

Secondary Insurance **C**ircle: Dental/Medical
Name of Subscriber:_____Birthday:_____Social Security #:_____

Relationship to patient:_____ Employer:_____

Employer Address:_____City:_____Zip:_____

Insurance Company:_____ Group #:_____ ID#:_____

Address:_____City/State:_____Zip:_____

Person Financially Responsible for account: (circle one) Self/Other
If other:
Name:_____ Relationship to patient:_____

Address:_____City:_____Zip:_____

Home Phone:( )_____Work Phone:( )_____x____Cell:( )_____

Social Security #:_____Birthday:_____Driver's License#:_____

Employer:_____

Address:_____City:_____Zip:_____

Emergency Contact:_____ Relationship:_____ Phone:( )_____

Address:_____City:_____Zip:_____

Second Emergency Contact :_____ Relationship:_____ Phone:( )_____

Address:_____City:_____Zip:_____

Name of referring Doctor:_____Date of last visit:_____
Address:_____Phone:( )_____
General Dentist:_____Date of last visit:_____
Address:_____Phone:( )_____
Primary Care Physician:_____Date of last visit:_____
Address:_____Phone:( )_____

Patient Name: _____

Kyle Yamamoto, D.D.S., M.D., M.S., Inc.

Medical History

Are you in good health? Yes/No _____ Height:_____ Weight:_____
Have you had any medical care within the past 2 years? Yes/No Reason: _____
Have you been a patient in the hospital during the past 5 years? Yes/No Dates/Reasons:_____
_____
_____
Are you allergic/sensitive to any drugs or medications? Yes/No Please list them:_____
Are you allergic to eggs or soy? Yes/No Are you able to swallow pills for your prescriptions? Yes/No
Do you take any drugs/medications/supplements? Yes/No Please list them and dosages:_____
_____
_____
Do you have osteoporosis/osteopenia? Yes/No Have you ever taken Fosamax (Alendronate), Actonel, Boniva, Prolia, Zometa or similar drugs? Yes/No Name of bone loss medication(s) and dates taken:_____
Women: Are you or could you be pregnant? Yes/No Weeks_____ Are you nursing? Yes/No Are you taking birth control pills? Yes/No
Have you ever had any of the following conditions? Please circle yes or no & give dates for each:

Heart (Surgery,Disease,Attack)	Yes No	Contact Lenses	Yes No	Asthma and/or Inhaler	Yes No
Chest Pain/Angina	Yes No	A.I.D.S.	Yes No	Sinus Trouble	Yes No
Stroke	Yes No	H.I.V. Positive	Yes No	Hay Fever	Yes No
Artificial Heart Valve	Yes No	MRSA/staph/other infections	Yes No	Chronic Cough	Yes No
Pacemaker/Defibrillator	Yes No	Cold Sores/Fever Blisters	Yes No	Emphysema	Yes No
Heart Murmur	Yes No	Venereal Disease	Yes No	Bronchitis	Yes No
Mitral Valve Prolapse	Yes No	Liver Disease	Yes No	Tuberculosis	Yes No
Congenital Heart Disease	Yes No	Hepatitis A B C (circle)	Yes No	Sleep Apnea/CPAP	Yes No
High/Low Blood Pressure	Yes No	Yellow Jaundice	Yes No	COPD	Yes No
Blood Transfusion	Yes No	Diabetes Type I or II	Yes No	Allergies	Yes No
Bruise Easily	Yes No	Ulcers	Yes No	Hives	Yes No
Hemophilia	Yes No	Glaucoma	Yes No	Latex Sensitivity	Yes No
Anemia	Yes No	Rheumatic Fever	Yes No	Artificial Joints	Yes No
Swollen Ankles	Yes No	Kidney Disease/Infection	Yes No	Arthritis/Rheumatism	Yes No
Fainting or Dizzy Spells	Yes No	Dialysis	Yes No	Diet (Special/Restricted)	Yes No
Psychiatric/Psychological Care	Yes No	Thyroid Disease	Yes No	Headaches	Yes No
Nervous/Anxious	Yes No	Cortisone Medication.	Yes No	Cancer	Yes No
Autism	Yes No	Neurological Disorders	Yes No	Tumor	Yes No
Alcohol/Drug Abuse	Yes No	Epilepsy/Seizures	Yes No	Radiation Therapy	Yes No
Lupus/autoimmune condition	Yes No	Alzheimer's/Dementia	Yes No	Chemotherapy	Yes No

Have you ever had any other breathing/lung problems such as pneumonia not listed above? Yes/No Reason: _____
_____
Do you smoke cigarettes/cigars/marijuana/e-cigarettes/chewing tobacco/other? Yes/No How many/how often?_____
Do you have a cough, cold or sinus problem presently? Yes/No Reason: _____
Have you ever had any radiation or surgical treatment for a growth, tumor or other condition? Yes/No Reason: _____
_____
Have you ever had any injury to your jaws or face? Yes/No Reason:_____
Do you have numbness or tingling in any part of your body? Yes/No Reason: _____
Are you subject to excessive bleeding? Yes/No Reason: _____
Do you drink alcohol? Yes/No. Circle: beer, wine, hard liquor How much/how often?_____
Have you ever had a local anesthetic (injections in the mouth to make you numb, examples: filling, root canal, extraction)? Yes/No
Have you ever had any difficulty with a local anesthetic? Yes/No What happened? _____
Have you ever had general anesthesia (been "asleep") during a hospital or dental visit? Yes/No
Have you ever had any difficulty with general anesthesia? Yes/No What happened? _____
Please indicate any further information concerning your medical/dental health not disclosed on this form:_____
_____
_____

I confirm as true the above health history information. If more information is needed, you have my permission to ask the respective healthcare provider/agency who may release such information to you. I will notify the doctor of any change in my health or medications.

Patient/Parent/Guardian Signature:_____Date:_____

Pharmacy Name:_____Phone Number_____ Address:_____

(For general anesthesia surgeries) Driver Name: _____ Relationship:_____ Phone:_____