Dr. Daniel Asatani D.D.S
2021 Ygnacio Valley Rd. Bldg. B Suite 3
Walnut Creek, CA 94598 (925) 939-3652

Welcome To Our Practice!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Patient Information

Date _____ Soc. Sec. # _____ Birthdate _____
Name _____
Last Name First Name Initial
Address _____ Home Phone _____
City _____ State _____ Zip _____
Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Employer _____ Business Phone _____
Business Address _____ Occupation _____
Whom may we thank for referring you? _____
In case of an emergency, who should we contact? _____ Phone _____

Primary Dental Insurance

Person responsible for account _____
Last Name First Name Initial
Relationship to patient _____ Birthdate _____ Soc. Sec. # _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Responsible party employed by _____ Business Phone _____
Business Address _____ Occupation _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

Additional Insurance

Insured name _____
Last Name First Name Initial
Relationship to patient _____ Birthdate _____ Soc. Sec.# _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Insured employed by _____ Business Phone _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

Dental History

Former Dentist _____ Date of last X-Rays _____
City, State _____ How often do you floss? _____
Date of last dental visit _____ How often do you brush? _____

Please check all that apply:

Bad breath ☐
Bleeding gums ☐
Blisters on lips or mouth ☐
Finger nail biting ☐
Grinding teeth ☐
Lip or cheek biting ☐
Loose teeth or broken fillings ☐
Orthodontic treatment ☐
Tooth pain ☐

Pain around ear ☐
Periodontal treatment ☐
Sensitivity to cold ☐
Sensitivity to heat ☐
Sensitivity to sweets ☐
Sensitivity when biting frequent headaches ☐
Jaw, head or neck injuries ☐
Jaw difficulty: Clicking and/or pain ☐

Medical History

Physician's name_____ Date of last visit_____

		Y	N
1.	Are you currently under medical treatment?	☐	☐
2.	Have you ever had any serious illnesses or operations?	☐	☐
3.	Are you currently taking any medication?	☐	☐
	Please describe:_____		
4.	Are you currently taking any diet drugs?	☐	☐
5.	Do you smoke?	☐	☐
6.	Do you use alcohol, cocaine or other drugs?	☐	☐
7.	Do you wear contact lenses?	☐	☐
8.	Have you had any allergic reactions to the following:		
	Local Anesthetics (eg. Novocaine)	☐	☐
	Penicillin or other Antibiotics	☐	☐
	Sulfa Drugs	☐	☐
	Barbiturates (sleeping pills)	☐	☐
	Sedatives	☐	☐
	Iodine	☐	☐
	Aspirin	☐	☐
	Latex	☐	☐
	Other	☐	☐
9.	(Women Only)Are you:		
	Pregnant?	☐	☐
	Nursing?	☐	☐
	Taking birth control pills?	☐	☐

Please check all that apply:

AIDS…….. ☐	Diabetes…….. ☐	Pacemaker…….. ☐
Anemia……... ☐	Emphysema…… ☐	Psychiatric care…….. ☐
Arthritis, Rheumatism ☐	Epilepsy……. ☐	Radiation treatment… ☐
Artificial heart valves ☐	Fainting or dizziness.. ☐	Respiratory disease… ☐
Artificial joints…….. ☐	Glaucoma……... ☐	Rheumatic fever……. ☐
Asthma……... ☐	Headaches…….. ☐	Scarlet fever……... ☐
Back problems…….. ☐	Heart murmurs…….. ☐	Shortness of breath… ☐
Bleeding abnormally, with extractions of surgery…… ☐	Heart problems…….. ☐ Hepatitis- Type - _____…… ☐	Sinus trouble…….. ☐ Skin rash…… ☐ Stroke…….
Blood disease……. ☐	Herpes…… ☐	Swelling of ☐
Cancer…… ☐	High blood pressure... ☐	feet/ankles…….. ☐
Chemical dependency ☐	HIV positive……... ☐	Swollen neck glands.. ☐
Chemotherapy…… ☐	Jaundice…… ☐	Thyroid problems….. ☐
Circulatory problems. ☐	Jaw pain……. ☐	Tonsillitis…….. ☐
Congenital heart lesions…… ☐	Kidney disease…….. ☐	Tuberculosis……... ☐
	Liver disease…….. ☐	Tumor or growth on ☐
Cortisone treatments.. ☐	Low blood pressure… ☐	head/neck……... ☐
Cough- persistent or bloody…… ☐	Mitral valve prolapse. ☐	Ulcer…….. ☐
	Nervous problems….. ☐	Venereal disease……

Assignment and Release

I hereby authorize payment directly to Dr. _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf of my dependents.

I authorize the above doctor and/or any provider of supplier of service in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____