DR. AKI SHIRAKURA & ASSOCIATES

Dr. Aki Shirakura and Associates
40 Bedford Road
Armonk, NY 10504
914-273-9280

PATIENT INFORMATION

Patient Name: _____

Preferred Name: _____

Date of Birth: _____ SSN: ___-__-____ Male __ Female __

Marital Status: _____ # of Children: _____

Address: _____
_____
_____

Person responsible for account: _____

Home Phone Number: _____

Work Phone Number: _____

Cell Phone Number: _____

Email address :_____

Preferred form of communication(please circle one):

Text Phone Call Email

How did you hear about us? _____

Referred by? _____

Date of last physical exam: _____

Are you now or have you recently been under a physician's care? YES NO

Reason: _____

Have you ever been a patient in a hospital or had any serious illness? YES NO

Explain: _____

_____

Are you currently taking medication? YES NO

If so, please list below the name of the medication and what it is for (ie. Lipitor - high cholesterol):

Medication	**Reason**

	Please circle one	
Are you currently a smoker?	YES	NO
Are you allergic or made sick by any medication:		
Local anesthetics (novocaine)	YES	NO
Penicillin	YES	NO
Sulfa drugs or other antibiotics	YES	NO
Aspirin, acetaminophen (Tylenol), or ibuprofen (Advil)	YES	NO
Codeine or other narcotics	YES	NO
Any other drugs or medications	YES	NO
If yes, please tell us. _____		
Do you have a PACEMAKER or JOINT REPLACEMENTS?	YES	NO
If so, which joint and what year was the surgery? _____		
Are you required to take pre-medication for surgery or prophylaxis treatment?	YES	NO

Please circle any of the following conditions that pertain to you currently or from the past:

Anemia
Anxiety
Arthritis
Artificial Joints
Asthma
Atrial Fibrillation
Bactrim
Behcet's Syndrome
Bell's Palsy
Blood Clot
Blood Disease
Blood Thinner
Cancer
Cardiac Ablation
Cataracts
Clotting Disorder
Cold Sores
Colon Resection
Depression
Diabetes
Dizziness
Dyslipidemia
Dysplasia
Ectasia of Ascending Thoracic Aorta
Eczema
Endocarditis
Epilepsy
Excessive Bleeding
Fainting
Fibromyalgia
Fluid Retention
Gallbladder
Gastroesophageal Reflux Disease
Glaucoma
Gout
Hashimoto Thyroid
Head Injuries
Hearing Impairment
Heart Attack
Heart Disease
Heart Murmur
Hepatitis
High Blood Pressure
High Cholesterol
Hip Replacement
HIV
Hypothyroid
Inflammation
Jaundice
Kidney Disease
Kidney Stones
Leukemia
Liver Disease
Lyme Disease
Mental Disorders
Migraine
Mitral Valve Prolapse
Mood Disorder
Myasthenia Gravis
Nervous Disorders
Neuropathy
No Epinephrine
Orthopedic Implants
Osteopenia
Osteoperosis
Other
Pacemaker
Parkinsons
Pre-Diabetes
Pregnancy
Pre-Med Needed
Prostate
Psoriasis
Pulmonary Embolism
Radiation Treatment
Ramapril
Respiratory Problems
Reynaud's Sjogrens
Rheumatic Fever
Rheumatism
Sarcoma
Schizoaffective Disorder
Seizures
Shoulder Replacement
Sinus Problems
Spinal Surgery
Stable Pulmonary Nodules
Stent
Stomach Problems
Stroke
Thyroid
Thyroidectomy
Tibial Plateau
TMJ
Trisomy 21
Trulicity
Tuberculosis
Tumors
Ulcers
Urinary Retention
Valsartin
Venereal Disease

	Please circle one	
Do you have any disease, condition, or problem not listed above?	YES	NO

Please explain: _____

_____

_____

WOMEN:

Are you pregnant?	YES	NO
Are you presently taking birth control or hormone replacement?	YES	NO

DENTAL HISTORY

	Please circle one	
Do your gums bleed when brushing your teeth?	YES	NO
Do you have any sores or swellings in your mouth?	YES	NO
Do you have jaw pain?	YES	NO
Do you have tension headaches?	YES	NO

Please share any other important information.

_____

_____

_____

_____

Are you interested in learning about any of the following procedures?

Invisalign (Orthodontic treatment)	YES	NO
Whitening	YES	NO
Veneers	YES	NO
Implants	YES	NO
Sleep Apnea Appliance	YES	NO

I attest that all information provided in this form is true and up to date as of the date below.
I will report any medical changes as necessary and in my annual Patient Information Update.

Signature: _____ **Date:** _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you

have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

Thank you for choosing Dr. Aki Shirakura and Associates for your dental care. We are so glad you're here!

In order to maintain our level of excellent care and current fees, we would like to stress the importance of keeping your scheduled appointments.

Cancellation Policy:*

Appointments canceled with 24 hours noticed will not incur a fee.

Appointments canceled with less than 24 hours notice will incur a $75 fee.

*No-shows** will incur the full appointment fee.*

Thanks so much for your cooperation!

~ Your Smile Team

* *We understand unforeseen circumstances can arise. We will make exceptions on a case by case basis.*

** *Multiple No-Shows will require a deposit of $25 (to be applied to the visit), when scheduling all future appointments*

Signature: _____ Date: _____