Rodney K. Kihara, D.D.S
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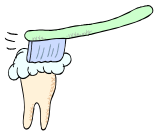

Patient Information

Date: _____ Patients Name: _____
Address: _____
Home Phone: (____)_____ Social Security: _____ _____ _____ Cell Phone #: ( )_____
Birthdate: _____/_____/_____ Parent's or Guardian's name (minors only):_____
If patient is a full-time student, fill in school name:_____
Emergency Contact: _____ Phone: (____)_____
Who referred you to our office: _____
Email Address: _____

Responsible Party Information

Name: _____
Address: _____
Home Phone: (____)_____ Work Phone: (____)_____ Fax: (____)_____ Birthdate: ____/____/____
Social Security: _____ _____ _____ Relation to Patient: _____
Employer: _____ Occupation: _____ No. Years Employed: _____
Employer Address: _____
Spouse's Name: _____
Social Security: _____ _____ _____ Birthdate: _____/_____/_____ Work Phone: (____)_____
Employer: _____ Occupation: _____ No. Years Employed: _____
Employer Address: _____

Insurance Information

Insured's Name: _____ Social Security: _____ _____ _____
Insurance Company: _____ Group No.:_____
Insurance Co. Address: _____ Ph.: (____)_____
Do you have dual coverage?: Yes____ No____ If yes, please complete the following information:
Insured's Name: _____ Social Security:_____ _____ _____
Insurance Company: _____ Group No.:_____
Insurance Co. Address: _____ Ph.: (____)_____

Dental Information

Do your gums bleed when you brush?: Yes____ No____
Are your teeth sensitive to heat or cold?: Yes____ No____
Pressure?: Yes____ No____ Sweets?: Yes____ No____
Date of last dental examination: _____ What kind, if any, X-rays were taken?: _____
How do you feel about the appearance of your teeth?: _____
Describe any current problems: _____