Robert T. Kimura, D.M.D., Inc.

11980 San Vicente Blvd., Ste. 500 • Los Angeles, CA 90049 • (310) 207-6111

Restorative and Cosmetic Dentistry

We are complimented that you have selected us to provide dental care for you and your family.

Whom may we thank for referring you to our office? _____

Patient Information

Date _____ Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Ph. # (___) _____ Work Ph. # (___) _____ Soc. Sec. # ___-___-___ Drivers Lic. # _____

Birthdate ___/___/___ Sex M F If patient is a minor, give parent's/guardian's name _____

Name of nearest relative not living with you _____ Relationship _____

If patient is a full-time student, fill in school name _____

E mail address _____ Cellular Ph. (___) _____ Pager Ph. # (___) _____

Emergency Contact _____ Ph. # (___) _____

Responsible Party Information

Name _____
Last First Middle Marital Status

Soc. Sec. #___-___-___ Birthdate ___/___/___ Relationship to Patient _____

Residence _____
Street Apt# City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Ph.# (___) _____ Work Ph.# (___) _____ Fax# (___) _____

Previous Address (if less than 3 years) _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____

Spouse's Name _____ Relationship to Patient _____

Soc. Sec. #___-___-___ Birthdate ___/___/___ Work Ph.# _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec # _____

Insurance Company _____ Group # _____

Is policy connected with your union? Yes ___ No ___ Name of Union _____ Local # _____

Do you have dual coverage? Yes ___ No ___ If yes: **Please complete the following secondary insurance information.**

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group # _____ Local # _____

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 ___

Do you grind or clench your teeth? Yes ___ No ___

Do you have any fear of dental work? Yes ___ No ___

Date of last dental visit _____ What was done at the time? _____

Former Dentist Name _____ City _____

How would you describe your current dental problem? _____

How do you feel about the appearance of your teeth? _____

Please complete back page →