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PATIENT INFORMATION				Date
Patient's Last Name	First	Middle Initial	Social Security Number	
What name would you like to be called by in our office		Date of Birth	Age	Sex Marital Status
Mailing Address	City	State	Zip	Home Telephone Number
Residence Address	City	State	Zip	Business Telephone Number
Additional Contact information: Cell Phone:		Pager:		
Occupation	Employer	Second Occupation	Second Employer	
<i>Who may we thank for referring you to our office?</i>				

Spouse/Responsible Party Information				
Spouse or Responsible Party Last Name	First	Middle Initial	Social Security Number	
Mailing Address	City	State	Zip	Home Telephone Number
Occupation	Employer	Date of Birth	Business Telephone Number	
Emergency Contact Last Name	First	Middle Initial	Relationship to Patient	
Mailing Address	City	State	Zip	Home Telephone Number

Dental Insurance Information-Primary Coverage				
Insured's Name	Insured's Employer		Social Security Number	
Insurance Company Name	Address	City	State	Zip
Membership/Group/Plan Numbers			Insurance Effective Date	

Dental Insurance Information-Secondary Coverage				
Insured's Name	Insured's Employer		Social Security Number	
Insurance Company Name	Address	City	State	Zip
Membership/Group/Plan Numbers			Insurance Effective Date	

Signature: _____
Patient or Parent if Minor