DENNIS D. IKUTA DDS INC.

Neuromuscular/Restorative, Cosmetic and Family Dentistry

Welcome. *The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve.*
The information on these forms will enable us to provide the best care possible for you.

Patient Information

❑ Dr. ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss

Name ____ Today's Date ___ / ___ / ___
First MI Last

We usually address our patients by their title and surname unless they request otherwise.

I prefer to be called ______________________ Birthdate ___ / ___ / ___ SS #: ______________

Home address ______________________________ City ______________ Zip ________

Home Ph #: ______________ Work Ph #: ______________ Pager / Cell Phone #: ______________

Email address ______________________ *Do you prefer to receive calls at:* ❑ Home ❑ Work ❑ Either

Responsible Party ______________________________ Birthdate __________ SS# ______________

Relation to Patient ____________ Employer __________________ Occupation ______________

Work Ph # ______________________

Spouse's name ______________________ Occupation ______________ Work Ph# ______________

How did you hear about our practice? ____

Other than your spouse, a person to contact in case of emergency: Name ______________________

Relation to patient ______________________ Home Ph # ______________ Work Ph # ______________

For our patients with dental insurance . . .

Name of policy holder ______________________ Birthdate ___ / ___ / ___ SS #: ______________

Insurance Co. ______________________________ Group #: ______________________

Name of employer ___________________________ Relation to patient ________________

Are you covered by another insurance plan?

Name of policy holder ______________________ Birthdate ___ / ___ / ___ SS #: ______________

Insurance Co. ______________________________ Group #: ______________________

Name of employer ___________________________ Relation to patient ________________

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Medical History

Patient Name ______________________________ Date ___ / ___ / ___

The thoroughness of this medical history is designed for your safety, and your complete answers will assist us in treating you with every consideration for your special needs. This information is confidential.

Name of personal physician ______________________________ Phone #: ______________

How do you assess your current health: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

If yes, please explain: ______________________________

Have you been hospitalized or had any serious medical problems within the past 5 years? ❑ Yes ❑ No

If yes, please explain: ______________________________

Do you have heart trouble or any form of cardiovascular disease? ❑ Yes ❑ No

- ❑ Angina (chest pains) Frequency ________
- ❑ Heart attack (date) ______________
- ❑ Heart surgery (date) ______________
  - ❑ Pacemaker
  - ❑ Bypass
  - ❑ Prosthetic heart valve
- ❑ Rheumatic Fever (date) __________
- ❑ Heart murmur / mitral valve prolapse
- ❑ High blood pressure
- ❑ Stroke (date) ______________
- ❑ Other ______________

Have you ever had or been treated for any of the following diseases or medical problems?

Yes	No		Yes	No	
❑	❑	Hepatitis/Jaundice	❑	❑	Abnormal bleeding
❑	❑	Epilepsy/Seizures/ Fainting	❑	❑	Kidney problems
❑	❑	Cancer/Chemotherapy	❑	❑	Diabetes
❑	❑	Psychiatric problems	❑	❑	Asthma or lung disease
❑	❑	Tuberculosis	❑	❑	Hip or joint replacement
❑	❑	AIDS/HIV	❑	❑	Anemia
❑	❑	Drug/Alcohol abuse	❑	❑	Arthritis
❑	❑	Ulcers	❑	❑	Glaucoma

Have you been treated for any other illnesses not listed above? ❑ Yes ❑ No If yes, please explain:

____

Are you allergic to any of the following medications?

Yes	No		Yes	No	
❑	❑	Penicillin	❑	❑	Dental Anesthetic
❑	❑	Erythromycin	❑	❑	Latex
❑	❑	Codeine	❑	❑	Aspirin

Are you allergic to any other pain medications or antibiotics? ❑ Yes ❑ No If yes, please list:

____

Have you ever been advised to take antibiotics before dental treatment? ❑ Yes ❑ No

Have you ever taken the diet pill phen fen? ❑ Yes ❑ No

Are you currently taking prescription medications? (If yes, please list below) ❑ Yes ❑ No

Name of Medication	Purpose

Do you use "Recreational" drugs ❑ Yes ❑ No

"Recreational" drugs such as cocaine, marijuana, stimulants or depressants (prescription and over-the-counter) may have dangerous interactions with local anesthetics or other common dental medications. Please describe the use of any drugs or discuss in complete confidentiality with the doctor.

____

Women: Are you pregnant? (Expected delivery date ____________) ❑ Yes ❑ No

Women: Are you taking birth control pills? ❑ Yes ❑ No

(Certain antibiotics may adversely interact with oral contraceptives.)

NOTES:

Patient's B.P. is: __________ Date: ________

Med. Hx. Rev. (int'l): ________ Date: ________

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medications, I will inform the doctor. If deemed advisable, I grant permission for my physician to be contacted for details and advise. I further authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation. Authorization is also given for dental treatment to be rendered by the doctor and office staff. I also give permission for the doctor or his staff to use any photos he may take to be used for lecturing or educational purposes. I understand that I am financially responsible for all treatment rendered, regardless of insurance involvement.

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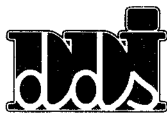
Signature of Patient or Guardian (if patient is a minor) Date



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Dental History

Patient Name ______________________________ Date ___ / ___ / ___

Your answers to this questionnaire will help us to understand what is important to you, so that we may more effecively treat you with consideration for your specific needs and desires.

Are any of your teeth sensitive to:

Hot or cold? Y N

Biting or chewing? Y N

Have you noticed mouth odors or bad tastes? Y N

Do you frequently get cold sores, blisters or any other oral lesions? Y N

Do your gums bleed or hurt? Y N

Have your parents experienced gum disease or tooth loss? Y N

Have you noticed any loose teeth or change in your bite? Y N

Does food get caught between your teeth? Y N

If yes, where?______________________

Do you:

Clench or grind your teeth while awake or asleep? Y N

Bite your lips or cheeks regularly? Y N

Mouth breathe while awake or asleep? Y N

Have tired jaws, especially in the morning? Y N

Smoke or chew tobacco? Y N

Feel nervous about having dental treatment? Y N

Have you ever had:

Orthodontic treatment? Y N

Oral surgery? Y N

Periodontal treatment? Y N

Your bite adjusted? Y N

A mouth or night guard? Y N

Have you experienced:

Clicking or popping of the jaw? Y N

Pain? (joint, ear, side of face) Y N

Difficulty in opening or closing your mouth? Y N

Difficulty in chewing on either Y N

side of your mouth? Y N

Headaches or neck pain? Y N

How often do you brush your teeth?

____________ Floss? ____________

What other dental aids do you use?

(Sonicare, WaterPik, toothpicks, etc.)

____

Have you ever had a less than positive dental experience? Y N

If you could easily and safely whiten your teeth, would you be interested? Y N

What are your chief dental concerns? ______________________________

____