IKUTA
Dental Health Center

DENNIS D. IKUTA, DDS | DERIC D. IKUTA, DDS

Welcome

The benefits of having great total dental health and a beautiful smile are immeasurable. It is our goal to offer comprehensive dental health services to help you achieve optimum overall health and well being to look and feel your best. The information provided on these forms will help us to provide the best possible care for you and is strictly confidential. Thank 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# _____ 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 contract 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. Your complete answers will assist us in treating you with every consideration for your health special needs. This information is confidential.

Name of personal physician_____ Phone #_____

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

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

If yes, please explain:_____

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

If yes, please explain:_____

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

❑ 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 conditions?

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
❑	❑	Drugs/Alcohol abuse	❑	❑	Arthritis
❑	❑	Ulcers	❑	❑	Glaucoma

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

_____

Are you allergic to any of the following medications?

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

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

_____

❑ Yes ❑ No 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)

Name of Medication Purpose

_____

_____

_____

_____

_____

_____

❑ Yes ❑ No Do you use "Recreational" drugs

"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.

_____

❑ Yes ❑ No *Women:* Are you pregnant? (expected delivery date _____)

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

(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 a 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.

_____

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

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Health and Dental Screening Questionnaire

We are concerned with your total health and well being. Your responses are strictly confidential. Answering these questions will help us evaluate and assess your condition and determine if additional information is needed in your health and dental assessment. Thank you for your cooperation.

Patient Name: _____ Date____/____/____

Dental History:

1. When was your last dental visit? _____
2. Any sensitive teeth? If yes, describe _____
3. Have you lost any teeth? If yes, where _____
4. Have you had any orthodontic treatment? If yes, when _____
5. Have you had any Oral surgery? If yes, when _____
   _____
6. How often do you brush your teeth? _____
7. Do you floss your teeth? If yes, how often? _____
8. Do you use any other dental aids? (Sonicare brush, Water Pik, toothpicks, etc.) _____
9. Have you ever had a less than positive dental experience? If yes, describe _____
   _____
10. Any fears or apprehension regarding your dental treatment? If yes, describe _____
    _____
11. What are your chief dental concerns or goals for your dental health, teeth, and smile? _____
    _____
    _____
    _____

Periodontal Disease:

1. ❑Yes ❑No Have you ever been informed that you have periodontal (gum) disease?
2. ❑Yes ❑No Do you ever notice bleeding from your gums when you brush or floss?
3. ❑Yes ❑No Do you ever notice a bad taste or unpleasant odor from your mouth?
4. ❑Yes ❑No Do you have loose or sore teeth?
5. ❑Yes ❑No Do you have any areas of receding gums?

Other comments about your gums:

_____

_____

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Sleep Apnea Screening:

1. ❑Yes ❑No Have you ever heard of the term "Sleep apnea" or "Sleep Breathing Disorder"?
2. ❑Yes ❑No Have you ever been told that you snore or make unusual sounds while sleeping?
3. ❑Yes ❑No Do you ever feel excessively tired or sleepy?
4. What is your Height?_____Weight?_____ Neck size?_____
5. ❑Yes ❑No Have you experienced any problems with your sleep? If yes, please explain:

_____

Other comments which may be helpful to assess your condition?

_____

_____

Headache and TMJ Screening:

1. ❑Yes ❑No Have you ever experienced headaches, migranes, or discomfort in the head, neck, jaw or facial areas? If yes, how often, and intensity level (rate 1-10, 1 being low and 10 highest):

_____

_____

2. ❑Yes ❑No Have you ever experienced tightness, popping, or clicking from your jaws?
3. ❑Yes ❑No Do you have any symptoms in the neck or shoulder areas?
4. ❑Yes ❑No Do you notice or suspect that you grind or clench your teeth?
5. ❑Yes ❑No Do you have any pressure, pain, or symptoms in your ears?
6. ❑Yes ❑No Any difficulty chewing or eating?

Other comments you would like to make regarding any head, neck, or TMJ symptoms?

_____

_____

Cosmetic Dentistry Screening:

1. ❑Yes ❑No Is there anything about your teeth and smile that you feel is noticable to others?
2. ❑Yes ❑No Is there anything about the appearance of your teeth and smile that you would like to improve?

Other comments about your appearance?

_____

_____