IKUTA 笑
Dental Health Center

PATIENT INFORMATION

☐ MR ☐ MRS ☐ DR ☐ MS ☐ MISS | ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

PATIENT'S NAME _____

AGE _____ DATE OF BIRTH _____ ☐ MALE ☐ FEMALE

ADDRESS _____

CITY, STATE, ZIP _____

HOME PHONE # _____ E-Mail Address _____

HOW LONG AT PRESENT ADDRESS? _____

IF LESS THAN 3 YEARS, PLEASE GIVE PREVIOUS ADDRESS.

PREVIOUS ADDRESS _____

CITY, STATE, ZIP _____

EMPLOYED BY _____

WORK PHONE # _____

IF THE PATIENT IS A MINOR, PLEASE FILL OUT THE BOX BELOW

☐ PARENT ☐ GUARDIAN NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

HOW LONG AT PRESENT ADDRESS? _____

SOCIAL SECURITY # _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

_____

We are a "fee for service" office and require payment at the time of service.
(Our returned check fee is $50)

INSURANCE INFORMATION We will gladly provide you with an insurance claim form and any necessary information for each visit. It is your responsibility to send your claim to your insurance company and follow up for payment. Please let us know if you have any questions.

INSURANCE COMPANY _____

GROUP NUMBER _____

PHONE NUMBER _____

INSURED'S NAME _____

EMPLOYER NAME _____

INSURED'S DATE OF BIRTH _____

I certify that the above information is correct to the best of my knowledge.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

ORDER

1. **Please order your *chief complaints* by number:**
   #1 being the 1st or most important,
   #2 the 2nd important,
   #3 the 3rd less important,
   #4, #5, #6…etc.
   (List all please)

FREQUENCY

2. **Rate your chief complaints for frequency as follows:**
   1= Seldom
   2= Occasional
   3= Frequent
   4= Every Day

INTENSITY

3. **Rate the intensity of each complaint ordered on a scale from 0-10.**
   0= No Pain to
   10= Most severe pain

Chief Complaint	ORDER	Frequency (1-4)	Intensity 0-10)	*For Office Use Only*
Jaw clicking/popping				
Jaw joint noises				
Jaw locking				
Muscle twitching				
Limited mouth opening				
Dizziness				
Headaches				
Visual disturbances				
Jaw pain				
Facial pain				
Ear pain				
Back pain				
Eye pain				
Neck pain				
Shoulder pain				
Pain when chewing				
Throat pain				
Ear congestion				
Sinus congestion				
Ringing in the ears				
Fatigue				
Frequent heavy snoring				
Snoring which affecting sleep of others				
Significant daytime drowsiness				
Stop breathing when sleeping				
Difficulty falling asleep				
Gasping when waking up				
Nighttime choking spells				
Feeling unrefreshed upon waking				
Morning hoarseness				
Swelling in ankles or feet				
Other_____				
Other_____				

I certify that the above information is correct to the best of my knowledge.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

Please answer the following questions as completely and accurately as you can. *Also*, *please* be as detailed as possible providing additional information you think is important. If you have any questions about this form, or your upcoming appointment, contact our office for assistance.

Please circle YES or NO. If YES, *please* explain on the line provided.

MEDICAL HISTORY:

1. YES NO Do you have a current medical problem? _____
2. YES NO Have you been told you have a heart murmur? _____
3. YES NO Do you have any heart problems? What kind? _____
4. YES NO Do you have ☐ High or ☐ Low Blood Pressure? Is it controlled? ☐ YES ☐ NO
5. YES NO Have you had rheumatic fever? When _____
6. YES NO Have you had pain in your chest or shortness of breath? _____
7. YES NO Do your ankles swell? _____
8. YES NO Has you physician ever told you that you are anemic? _____
9. YES NO Have you ever had a stroke? When? _____
10. YES NO Have you ever had epilepsy? _____
11. YES NO Do you have diabetes? Is it controlled? _____
12. YES NO Do you have fainting or dizzy spells? _____
13. YES NO Do you feel like your sense of balance has changed? _____
14. YES NO Do you have headaches? How often? Where? _____
15. YES NO Do you take Aspirin, Advil, Tylenol or another pain reliever? How often? _____
16. YES NO Have you been advised not to take any medication? What? _____
17. YES NO Do you have asthma or hay fever? How is it controlled? _____
18. YES NO Have you ever had tuberculosis? When? _____
19. YES NO Have you ever had glaucoma? When? _____
20. YES NO Have you ever had hepatitis? When? _____
21. YES NO Do you have arthritis? How is it controlled? _____
22. YES NO Have you ever had a tumor or cancer? How was it treated? _____
23. YES NO Have you ever had any major surgeries? What kind? _____
24. YES NO Have you ever been injured in an accident? When? _____
25. YES NO Have you ever had a severe blow to the head? When? _____
26. YES NO Are your hands and/or feet cold? How often? _____
27. YES NO Is your diet medically supervised? For what purpose? _____
28. YES NO Do you have difficulty swallowing? _____
29. YES NO Do you have a feeling of something stuck in your throat? _____
30. YES NO Do you ever have any facial pain or pressure? Where? _____
31. YES NO Do you ever have any pain or pressure behind your eyes? _____
32. YES NO Are you aware of stiff neck muscles? How often? _____
33. YES NO Have you been in traction for a neck injury? When? _____
34. YES NO Have you ever had or been advised to have neck surgery? _____
35. YES NO Do you have back pain? Where? _____
36. YES NO Do your ears feel itchy, stuffy or congested? _____
37. YES NO Do you have difficulty with pain in your ears when changing altitude? _____
38. YES NO Do your ears ring, buzz or hiss? How often? _____

I certify that the above information is correct to the best of my knowledge.

PATIENT/GUARDIAN SIGNATURE

_____DATE_____

39. YES NO Have you noticed any changes in your hearing? _____
40. YES NO Are you depressed? _____
41. YES NO Do you have emotional or anxiety/nervous problems? _____
42. YES NO Have you ever been treated for emotional or anxiety/nervous problems? _____
43. YES NO Have you ☐ gained or ☐ lost weight within the last year? How much? _____
44. YES NO Do you take more than one alcoholic drink per day? How many? _____
45. YES NO Do you use tobacco? How much? _____
46. YES NO Have you had any other serious illnesses, hospitalization or accidents? _____
    Please explain: _____

Please list ALL medications and the dosage you are currently taking:

1._____ 2._____ 3._____ 4._____

5._____ 6._____ 7._____ 8._____

Please list any allergies to any **medications**:

1._____ 2._____ 3._____ 4._____

Other allergies:

1._____ 2._____ 3._____ 4._____

DENTAL HISTORY:

47. YES NO When was your last dental visit? _____
48. YES NO Have you been told that you have periodontal (gum) disease? _____
49. YES NO Do you have any existing problems with your teeth? Describe _____
50. YES NO Is any dental treatment planned? Describe _____
51. YES NO Do you bite your nails? _____
52. YES NO Have you ever had oral surgery? _____
53. YES NO Have you lost any teeth? From what cause? _____
54. YES NO Have the teeth been replaced? When? _____
55. YES NO Have you ever had orthodontic treatment? When? _____
56. YES NO Have you ever had extensive dental treatment? When? _____
57. YES NO Is any part of your mouth sensitive to temperature, pressure, food or drink?
    Where? _____
58. YES NO Do you wear dentures or partial dentures? Are they comfortable? YES NO

TMJ HISTORY

59. YES NO Do you ever have a burning or painful sensation in your mouth? _____
60. YES NO Do you get popping, clicking, or grinding noises when you open or close? _____
61. YES NO Do you ever awaken with an awareness of your teeth or jaws? _____
62. YES NO Are you aware of clenching during the daytime? How often? _____
63. YES NO Have you ever been told you grind your teeth during sleep? _____
64. YES NO Do you have trouble opening your mouth widely? _____
65. YES NO Does your jaw ever lock open or closed? How often? _____
66. YES NO Do you feel your bite is different, unstable or uncomfortable? _____
67. What professional advice or treatment have you had regarding your TMJ, headaches or pain conditions/problems? _____
68. YES NO If you sought treatment for a TMJ problem, did it help? _____
69. YES NO Do you or have you had any pain in any of the following areas? (circle)

Jaw Ear Face Neck Teeth Head Other _____

70. YES NO Do your jaw problems affect your ability to chew? _____
71. YES NO Has your diet changed due to your jaw problems? Describe _____
72. YES NO Do your joint noises affect others while eating? _____

I certify that the above information is correct to the best of my knowledge.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

FAMILY HISTORY:

73. YES NO Do you have children. What are their ages? _____
74. YES NO Does your partner help you? _____
75. YES NO Do you have houseguests? _____
76. YES NO Does your job satisfy you? _____

FOR WOMEN:

77. YES NO Are you pregnant? Expected delivery date? _____
78. YES NO Do you have a history of miscarriages? When? _____
79. YES NO Have you reached menopause? _____

SLEEP, SNORING AND APNEA HISTORY

80. YES NO Do you become easily fatigued? At what time of day? _____
81. YES NO Do you have problems with insomnia? _____
82. YES NO Do you sleep well? How long? _____
83. YES NO Do you dream? How often? _____
84. YES NO Do you have trouble falling asleep or staying asleep? Which _____
85. YES NO Do you snore or have you been told you do? _____
86. YES NO Do you wake up with a headache? _____
87. YES NO Have you had chronic sleepiness, fatigue or weariness that you can't explain? _____
88. YES NO Do you often fall asleep reading or watching television? _____
89. YES NO Have you fallen asleep during the day against your will? _____
90. YES NO Have you had to pull off the road while driving due to sleepiness? _____
91. YES NO Have you been more irritable and short tempered? _____
92. YES NO Have you felt that your memory and/or intellect is impaired? _____
93. YES NO Have you been told that you stop breathing while asleep? _____
94. About how many times per night do you wake up? _____
95. What time do you normally go to bed? _____ Get up in the morning? _____
96. Of the hours you are in bed, about how many hours are you asleep? _____
97. Would you rate the quality of your sleep as ☐ Good ☐ Fair ☐ Poor?
98. YES NO Do you have difficulty breathing through your nose? _____
99. Present body weight: _____ lbs. Height _____ ft. _____ inches.
100. YES NO Have you been diagnosed or treated for a sleep disorder? When _____
101. YES NO Have any immediate family members been diagnosed or treated for a sleep disorder?
102. YES NO Have you ever had an evaluation at a sleep center?
Sleep Center Name: _____
Location: _____
Sleep Study Date: _____
103. What professional advice or treatment have you received about your snoring or sleep apnea?
_____
_____
104. YES NO If you sought treatment for a sleep disorder, did it help? _____
_____

I certify that the above information is correct to the best of my knowledge.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

When did your symptoms first start?

Was there a specific incident, accident or injury that seemed to trigger your symptoms?

Do your present symptoms affect relationships with family and friends? If so, how?

What are your expectations in seeking treatment at this time?

What do you see yourself doing, after treatment that you are not able to do now?

ATTORNEY INFORMATION

Are you involved in a lawsuit regarding your condition? ☐ YES ☐ NO

If you have an attorney representing you, please complete the following:

Attorney's Name _____

Paralegal _____

Phone Number _____

Address _____

City, State, Zip _____

Please use this space to tell us anything about your condition(s) that were not mentioned in this questionnaire. _____

I certify that the above information is correct to the best of my knowledge.

PATIENT/GUARDIAN SIGNATURE _____ DATE_____

Symptoms

HEAD PAIN

__Yes __No Entire head (Generalized)
[L] [R] [B] Front of your head (Frontal)
__Yes __No Top of the Head
[L] [R] [B] Back of your head
[L] [R] [B] In your temples

JAW PAIN

[L] [R] [B] Jaw pain - on opening
[L] [R] [B] Jaw pain - while chewing
[L] [R] [B] Jaw pain - at rest

JAW SYMPTOMS

[L] [R] [B] Jaw clicking
__Yes __No Jaw locks closed
__Yes __No Jaw locks open
__Yes __No Jaw popping
__Yes __No Teeth grinding

MOUTH AND NOSE RELATED CONDITION

__Yes __No Broken teeth
__Yes __No Teeth clenching
__Yes __No Dry mouth
__Yes __No Frequent snoring
__Yes __No Frequent biting of cheek
__Yes __No Burning tongue

EAR RELATED CONDITIONS

__Yes __No Buzzing in the ears
__Yes __No Tinnitus (ringing in the ears)
__Yes __No Ear pain
__Yes __No Ear congestion
__Yes __No Pain in front of the ear
__Yes __No Hearing loss
__Yes __No Recurrent ear infections
__Yes __No Pain behind the ear

EYE RELATED CONDITIONS

Double Vison, Photophobia in PAIN Hx

__Yes __No Blurred vision
__Yes __No Eye pain
__Yes __No Pain or pressure behind the eyes

THROAT, NECK & BACK RELATED CONDITIONS CONTINUED

__Yes __No Back pain - lower
__Yes __No Back pain - middle
__Yes __No Back pain - upper
__Yes __No Chronic sore throat
__Yes __No Constant feeling of a foreign object in throat
__Yes __No Difficulty in swallowing
__Yes __No Limited movement of neck
__Yes __No Neck pain
__Yes __No Numbness in the hands or fingers
__Yes __No Sciatica
__Yes __No Scoliosis
__Yes __No Shoulder pain
__Yes __No Shoulder stiffness
__Yes __No Swelling in the neck
__Yes __No Swollen glands
__Yes __No Thyroid enlargement
__Yes __No Tightness in throat
__Yes __No Tingling in the hands or fingers
__Yes __No Chronic sinusitis

Other _____ _____

Patient Signature _____ Date _____

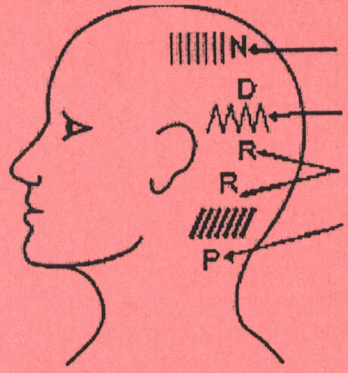
DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

MILD PAIN |||||||

MODERATE PAIN ^^^^

SEVERE PAIN ////////

B Burning
D Dull
N Numbing
P Pressure
S Sharp
T Tingling
R Radiating

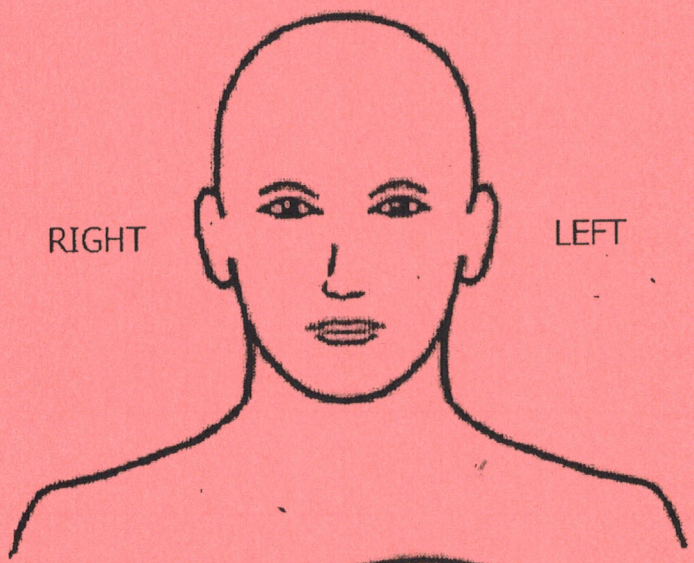


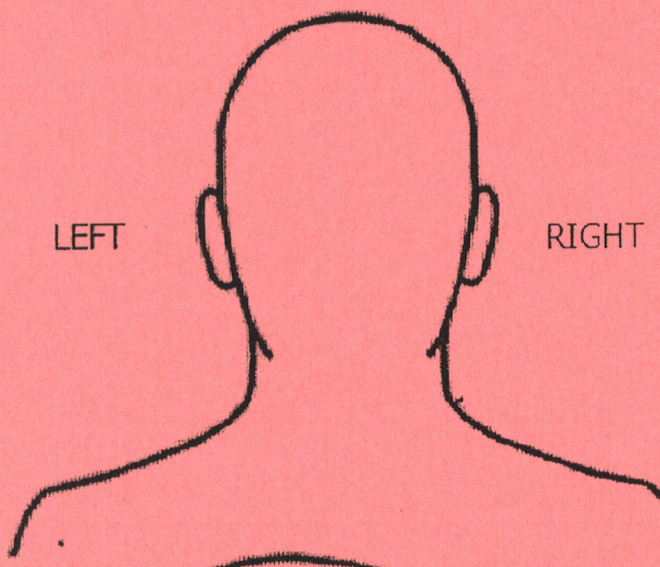
Mild, numbing pain

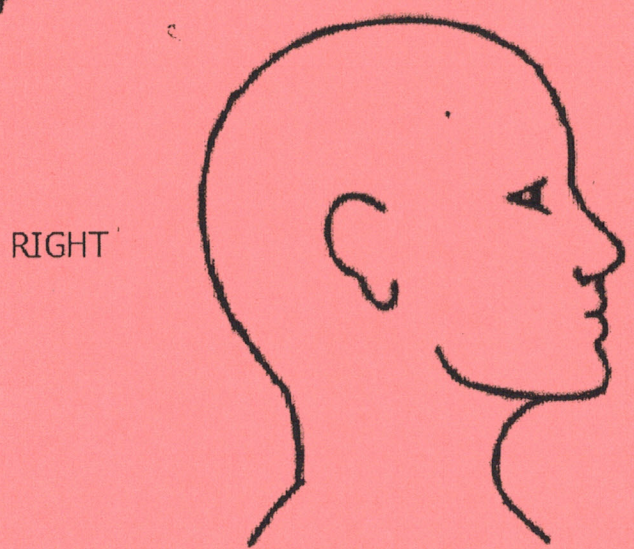
Moderate, dull pain

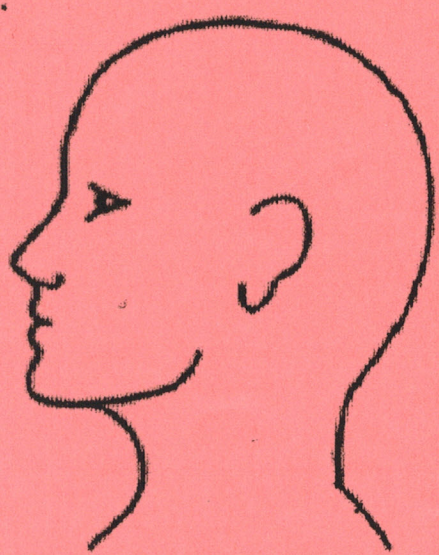
Severe, radiating pain

Pressure









IKUTA 笑
Dental Health Center

BED PARTNER SURVEY
GIVE TO BED PARTNER

To help us with a proper diagnosis and appropriate treatment plan, have your bed partner, if applicable and available, fill out this questionnaire regarding YOUR sleep habits. This information is vitally important for Dr. Allman to best evaluate your current condition.

TO BE FILLED OUT BY THE PATIENT'S BED PARTNER

Patient's Name _____

1. YES NO Are there ever times your bed partner has to sleep in another room?_____
2. YES NO Do you witness the patient snoring?_____
3. YES NO Do you witness the patient choking or gasping for breath during sleep?
4. YES NO Does the patient pause or stop breathing during sleep?_____
5. YES NO Does the patient fall asleep easily, if given the opportunity, during the day (normal wakeful hours)?_____
6. YES NO Do you witness the patient clenching and/or grinding his/her teeth during sleep?
7. YES NO Does the patient appear refreshed upon waking?_____
8. YES NO Do the patient's sleep habits disturb your sleep?_____
9. YES NO Does the patient sit up in bed, not awake?_____
10. Please check those sleep habits of the patient that are disturbing to you:

- ☐ Snores
- ☐ Restless
- ☐ Wakes up often
- ☐ Loud gasping for breath while sleeping
- ☐ Stops breathing
- ☐ Grinds teeth
- ☐ Becoming very rigid or shaking
- ☐ Biting tongue
- ☐ Kicking during sleep
- ☐ Head rocking or banging
- ☐ Bed-wetting
- ☐ Sleep walking
- ☐ Sleep talking

☐ Other_____

Comments:_____

~ OVER ~

IKUTA 笑
Dental Health Center

BED PARTNER SURVEY

GIVE TO BED PARTNER

How likely is your partner to doze off or fall asleep in the following situations, in contrast to just feeling tired?

This refers to daily life in recent times, if these things have not occurred recently, try to work out how they would have affected your partner.

Use the following scale and choose the most appropriate number for each situation:

Sitting and reading _____
Watching TV _____
Sitting inactive in a public place (e.g. A theater or a meeting) _____
As a passenger in a car for an hour without a break _____
Lying down to rest in the afternoon when circumstances permit _____
Sitting and talking to someone _____
Sitting quietly after a lunch without alcohol _____
In a car, while stopped for a few minutes in traffic _____

0 = Would **never** doze

1 = **Slight** chance of dozing

2 = **Moderate** chance of dozing

3 = **High** chance of dozing

Additional comments regarding the patient's sleep habits not mentioned above:

_____

_____

Please sign and date at the bottom of this form and many thanks for your help.

Partner's Signature_____ Date_____

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

Use the following scale and choose the most appropriate number for each situation:

Sitting and reading _____	**0** = Would **never** doze
Watching TV _____	**1** = **Slight** chance of dozing
Sitting inactive in a public place (e.g. A theater or a meeting) _____	
As a passenger in a car for an hour without a break _____	**2** = **Moderate** chance of dozing
Lying down to rest in the afternoon when circumstances permit _____	
Sitting and talking to someone _____	**3** = **High** chance of dozing
Sitting quietly after a lunch without alcohol _____	
In a car, while stopped for a few minutes in traffic _____	

IF YOU HAVE NOT WORN A CPAP DEVICE, SKIP THIS SECTION AND TURN THE PAGE!

CPAP HISTORY:

YES NO Do you wear a CPAP device **successfully** during sleeping?
How many hours per night do you wear your CPAP?

_____

YES NO Have you tried other therapies for your sleeping disorder?
Please list other therapies (Weight-loss attempts, smoking cessation, surgeries, etc.)_____

_____

If you are unable to wear a CPAP device, please check below reasons for your difficulty.

- ☐ Mask Leaks
- ☐ Mask Uncomfortable/Device Uncomfortable
- ☐ Unable to sleep comfortably
- ☐ Noise disturbs my sleep and/or bed partner's sleep
- ☐ Restricts movement during sleep
- ☐ Does not seem to be effective
- ☐ Straps/headgear cause discomfort
- ☐ Pressure on the upper lip causes tooth related problems
- ☐ Latex Allergy
- ☐ Claustrophobia
- ☐ Other_____

I certify that the above information is correct to the best of my knowledge.

PATIENT/GUARDIAN SIGNATURE _____DATE_____

Berlin Questionnaire Sleep Evaluation

category 1

1. Complete the following:

   Height ___ ft ___ in

   Weight ___ Age ___

2. Do you snore?

   - ☐ yes
   - ☐ no
   - ☐ don't know

If you snore: *(Answer questions 3-6)*

3. Your snoring is?

   - ☐ slightly louder than breathing
   - ☐ as loud as talking
   - ☐ louder than talking
   - ☐ very loud. Can be heard in adjacent rooms

4. How often do you snore?

   - ☐ nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ never or nearly never

5. Has your snoring ever bothered other people?

   - ☐ yes
   - ☐ no

6. Has anyone noticed that you quit breathing during your sleep?

   - ☐ nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ never or nearly never

category 2

7. How often do you feel tired or fatigued after your sleep?

   - ☐ nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ never or nearly never

8. During your waketime, do you feel tired, fatigued or not up to par?

   - ☐ nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ never or nearly never

9. Have you ever nodded off or fallen asleep while driving a vehicle?

   - ☐ yes
   - ☐ no

   If yes, how often does it occur?

   - ☐ nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ never or nearly never

category 3

10. Do you have high blood pressure?

    - ☐ yes
    - ☐ no
    - ☐ don't know

(For office use)

Scoring Questions: Any answer within the box is a positive response

Scoring categories

- ☐ Category 1 is positive with 2 or more positive responses to questions 2-6
- ☐ Category 2 is positive with 2 or more positive responses to questions 7-9
- ☐ Category 3 is positive with 1 positive response and/or a BMI > 30

Score: ___

(BMI = Body Mass Index)

Final Result: 2 or more possible categories indicates a high likelihood of sleep disordered breathing.

Patient Signature _____ Date _____

FATIGUE SCALE

During the past week:

	No << 1	2	3	4	5	6	7 >> Yes
I felt fatigued and had less motivation	☐	☐	☐	☐	☐	☐	☐
I felt fatigued and did not desire to exercise	☐	☐	☐	☐	☐	☐	☐
I felt fatigued often	☐	☐	☐	☐	☐	☐	☐
I felt fatigue that interfered with my physical functioning	☐	☐	☐	☐	☐	☐	☐
I felt fatigued which caused me frequent problems	☐	☐	☐	☐	☐	☐	☐
I felt fatigued which prevented sustained physical functioning	☐	☐	☐	☐	☐	☐	☐
I felt fatigued and couldn't carry out certain duties and responsibilities	☐	☐	☐	☐	☐	☐	☐
Fatigue was among my three most disabling symptoms	☐	☐	☐	☐	☐	☐	☐
Fatigue interfered with my work, family or social life	☐	☐	☐	☐	☐	☐	☐

Total Score: ____

SLEEP STUDIES

Have you ever had an evaluation at a Sleep Center? ☐ Yes ☐ No

☐ Home Sleep Study ☐ Polysomnographic evaluation performed at sleep disorder center

Sleep Center Name _____

Sleep Study Date _____

FOR OFFICE USE ONLY

The evaluation confirmed a diagnosis of
[ ] moderate obstructive sleep apnea
[ ] severe obstructive sleep apnea
[ ] mild obstructive sleep apnea

The evaluation showed

		during REM	*Supine*	*Side*
an RDI of	____	____	____	____
an AHI of	____	____	____	____

a nadir SpO2 of ____ T90 ____ ODI (Oxygen Desaturation Index)

Slow Wave Sleep ☐ Decreased ☐ None

REM Sleep ☐ Decreased ☐ None

Patient Signature _____ Date _____

Please take a moment to read our office policies and feel free to ask any questions you may have.

CONSENT FOR TREATMENT

I hereby authorize the Office Dr. Dennis and Deric Ikuta D.D.S. and designated staff to take x-rays, study models, photographs, electro-diagnostic studies and other diagnostic aids deemed appropriate to make a thorough diagnosis.

Upon such diagnosis, I authorize Dr. Ikuta and Dr. Deric and staff to perform all recommended treatment mutually agreed upon by me and to employ such professional assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I authorize the release of a full report of examination findings, diagnosis, treatment program and ongoing progress report to any referring dentist, physician, chiropractor or other health care professionals as indicated on the following page. I additionally authorize the release of any medical information to insurance companies for legal documentation to process claims. **I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.**

FINANCIAL POLICY

Payment is expected the day of your procedure as outlined verbally and/or in the written financial arrangement. We accept cash, check, MasterCard/Visa and Discover. For our patients carrying medical insurance, we do not accept assignment of benefits. However, we are happy to assist you with your insurance billing as a courtesy, though financial responsibility lies with you. Please ask our Patient Coordinators about your insurance issues.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received as agreed, I understand that a late charge of 1.5% on monthly balances will be added to my account and my account may be turned over for legal collection of any overdue amount. I understand that a credit history may be secured. Our returned check fee is $25.

Our goal is to eliminate "billing surprises" so let us help you plan your treatment carefully by addressing your financial concerns before treatment begins.

APPOINTMENTS

Should you need to cancel an appointment, we ask that you notify our office at least **24 hours in advance**. If you fail to cancel your appointment appropriately or do not show up for your scheduled appointment, you will be charged a broken appointment fee of **$75**.

I have read and understand The office of Dr. Dennis and Deric Ikuta D.D.S. Consent for Treatment, Financial and Appointment policies. I have had all of my questions regarding these issues answered by a Patient Coordinator and agree to abide by these policies.

Patient Signature: _____ Date: _____

Parent/
Responsible Party Signature: _____ Date: _____

Relationship: _____ Witness: _____

To better coordinate your treatment, please list the professionals you have consulted regarding your present symptoms. Please be sure to list your primary physician and family dentist. *Please initial* if you want us to send them a report from your visit.

Initial _____ **FAMILY PHYSICIAN**

Name _____
Address _____
_____
Phone _____

Initial _____ **DENTIST**

Name _____
Address _____
_____
Phone _____

Initial _____ **CHIROPRACTOR**

Name _____
Address _____
_____
Phone _____

Initial _____ **PHYSICAL THERAPIST**

Name _____
Address _____
_____
Phone _____

Initial _____ **ENT**

Name _____
Address _____
_____
Phone _____

Initial _____ **CARDIOLOGIST**

Name _____
Address _____
_____
Phone _____

Initial _____ **ALLERGIST**

Name _____
Address _____
_____
Phone _____

Initial _____ **NEUROLOGIST**

Name _____
Address _____
_____
Phone _____

Initial _____ **PSYCHIATRIST**

Name _____
Address _____
_____
Phone _____

Initial _____ **PSYCHOLOGIST**

Name _____
Address _____
_____
Phone _____

Initial _____ **PULMONOLOGIST**

Name _____
Address _____
Phone _____

Initial _____ **OTHER**

Name _____
Address _____
Phone _____

☐ **I understand and agree to have the indicated professionals I have listed above be sent initial information and ongoing updates regarding my diagnoses and treatment.**

☐ **I do not wish to have my records sent at this time.**

I certify that the above information is correct to the best of my knowledge.

PATIENT/GUARDIAN SIGNATURE _____

DATE _____