Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out these forms completely in ink. If you have any questions or need assistance, please ask us, we will be happy to help.

PATIENT INFORMATION

Name (*Last, First*) _____

Cell Phone _____ Email _____

Home Phone _____ Work Phone _____

Address _____ City _____ State _____ Zip_____

Birth Date _____Sex ☐M ☐F Status ☐Single ☐Married ☐Minor ☐Divorced ☐Widowed

Soc. Sec # _____ Driver's Lic _____

Occupation _____Employer_____WorkHours_____

Contact in case of emergency_____Relationship_____ Phone_____

Insurance Company _____Group # _____Relationship to patient_____

Name of policy holder_____ Soc. Sec # _____Policy holder's DOB_____

REFERRAL INFORMATION

How did you hear about us?

☐Family _____ ☐Friend _____ ☐Coworker_____

☐Signs ☐Insurance ☐Yelp ☐Website ☐Other_____

DENTAL CONCERNS

What are your present dental problems? _____

When was your last dental appointment? _____ Why did you leave your last dentist? _____

Are your teeth sensitive to sweets, hot/cold, or biting pressure? ☐yes ☐no

Does dental treatment make you nervous? ☐no ☐slightly ☐moderately ☐very

I think my dental health is … ☐excellent ☐good ☐fair ☐poor

If I could change my smile I would make my teeth …☐whiter ☐straighter ☐close spaces ☐repair chips

I have received a copy of Notice of Privacy Practices and Dental Materials Fact Sheet. _____ Initials

DENTAL TREATMENT CONSENT FORM

Patient Name _____

Please read and initial the items checked below and sign at the bottom of the page

☐ **1. WORK TO BE DONE**

I understand that I am having the following work done: Exam/Xrays____Fillings____Crowns/ Bridges____ Extractions_____General Anesthesia_____Root Canal_____Other_____ (Initials _____)

☐ **2. DRUGS AND MEDICATIONS**

I understand that antibiotics and analgesics and other medications can cause allergic reactions, including redness, swelling of tissues, pain, itching, vomiting, and/ or anaphylactic shock (severe allergic reactions) (Initials _____)

☐ **3. CHANGES IN TREATMENT PLANT**

I understand that during treatments it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary (Initials _____)

☐ **4. REMOVAL OF TEETH**

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth_____and any others necessary for reasons in paragraph #3. I understand removing teeth does net always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or the following treatment, the cost of which is my responsibility. (Initials _____)

☐ **5. CROWN, BRIDGES**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, (including shape, fit, size, and color) will be before cementation. (Initials_____)

☐ **6. DENTURES, COMPLETE OR PARTIAL**

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the “teeth in wax" try-in visit. I understand, that most dentures require refining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. Initials_____)

☐ **7. ENDODONTIC TREATMENT (ROOT CANAL)**

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). (Initials_____)

☐ **8. PERIODONTAL LOSS (TISSUE & BONE)**

I understand that I have a serious condition, causing gum and bone Inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

(Initials_____)

I understand that dentiststry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient _____Date_____

Signature of Parent/ Guardian if patient is a minor _____ Date_____

Signature of Dentist _____ Date_____

MEDICAL HISTORY

Patient Name _____ **Date of birth**_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions

Are you under a physician's care now? __ Yes __ No If yes_____
Have you ever been hospitalized or had a major operation? __ Yes __ No If yes_____
Have you ever had a serious head or neck surgery? __ Yes __ No If yes_____
Are you taking any medications, pills or drugs? __ Yes __ No If yes_____
Have you ever taken Fosamax, Boniva, Actonel or any medications that contain bisphosphonates (medications to treat osteoporosis) __ Yes __ No If yes_____
Are you on a special diet? __Yes __ No If yes_____
Do you, or did you, use tobacco? __Yes __ No

Women: Are you...
__ Pregnant/ Trying to get pregnant? __ Nursing __Taking Oral Contraceptives?

Are you allergic to any of the following?
__ Aspirin __ Penicillin/Amoxicillin __ Codeine __ Acrylic
__ Metal __ Latex __ Sulfa drugs __ Local Anesthetics
Other? If yes, please list _____

Do you use controlled substances? __ Yes __ No If yes, please list _____

Do you have, or have you had, any of the following conditions

AIDS/HIV Positive	__ Yes __ No	Cortisone Medicine	__ Yes __ No	Hemophilia	__ Yes __ No	Radiation Treatments	__ Yes __ No
Alzheimer's Disease	__ Yes __ No	Diabetes	__ Yes __ No	Hepatitis A	__ Yes __ No	Recent Weight Loss	__ Yes __ No
Anaphylaxis	__ Yes __No	Drug Addiction	__ Yes __ No	Hepatitis B or C	__ Yes __ No	Renal Dialysis	__ Yes __ No
Anemia	__ Yes __ No	Easily Winded	__ Yes __ No	Herpes	__ Yes __ No	Rheumatic Fever	__ Yes __ No
Angina	__ Yes __ No	Emphysema	__ Yes __ No	High Blood Pressure	__ Yes __ No	Rheumatism	__ Yes __ No
Arthritis/ Gout	__ Yes __ No	Epilepsy/ Seizures	__ Yes __ No	High Cholesterol	__ Yes __ No	Scarlet Fever	__ Yes __ No
Artificial Heart Valve	__ Yes __ No	Excessive Bleeding	__ Yes __ No	Hives/ Rash	__ Yes __ No	Shingles	__ Yes __ No
Artificial Joint	__ Yes __ No	Excessive Thirst	__ Yes __ No	Hypoglycemia	__ Yes __ No	Sickle Cell Disease	__ Yes __ No
Asthma	__ Yes __ No	Fainting Spells/ Dizziness	__ Yes __ No	Irregular Heartbeat	__ Yes __ No	Sinus Trouble	__ Yes __ No
Blood Disease	__ Yes __ No	Frequent Cough	__ Yes __ No	Kidney Problems	__ Yes __ No	Spina Bifida	__ Yes __ No
Blood Transfusion	__ Yes __ No	Frequent Diarrhea	__ Yes __ No	Leukemia	__ Yes __ No	Stomach/ Intestinal Disease	__ Yes __ No
Breathing Problems	__ Yes __ No	Frequent Headaches	__ Yes __ No	Liver Disease	__ Yes __ No	Stroke	__ Yes __ No
Bruise Easily	__ Yes __ No	Genital Herpes	__ Yes __ No	Low Blood Pressure	__ Yes __ No	Swelling of Limbs	__ Yes __ No
Cancer	__ Yes __ No	Glaucoma	__ Yes __ No	Lung Disease	__ Yes __ No	Thyroid Disease	__ Yes __ No
Chemotherapy	__ Yes __ No	Hay Fever	__ Yes __ No	Mitral Valve Prolapse	__ Yes __ No	Tonsilitis	__ Yes __ No
Chest Pains	__ Yes __ No	Heart Attack/ Failure	__ Yes __ No	Osteoporosis	__ Yes __ No	Tuberculosis	__ Yes __ No
Cold sores/ Fever Blisters	__ Yes __ No	Heart Murmur	__ Yes __ No	Pain in Jaw Joints	__ Yes __ No	Tumors or Growths	__ Yes __ No
Congenital Heart Disorder	__ Yes __ No	Heart Pacemaker	__ Yes __ No	Parathyroid Disease	__ Yes __ No	Ulcers	__ Yes __ No
Convulsions	__Yes __ No	Heart Problem/ Disease	__ Yes __ No	Psychiatric Disease	__ Yes __ No	Venereal Disease	__ Yes __ No
						Yellow Jaundice	__ Yes __ No

Have you ever had any serious illness not listed? __ Yes __ No If yes
_____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status

Signature of Patient/ Parent/ Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____