PATIENT INFORMATION

Please Circle One: Mr. Mrs. Ms. Miss Dr.

First Name _____ Initial _____

Last Name _____

Preferred to be Called: _____

Address _____

_____

City _____ State _____ Zip _____

Sex M F Birth Date _____ Age _____

Employer/School _____

Occupation _____

SS # _____ NCDL# _____

PERSON RESPONSIBLE FOR ACCOUNT

Please Circle One: Mr. Mrs. Ms. Miss Dr.

First Name_____ Initial_____

Last Name_____

Address_____

_____

City _____ State_____ Zip _____

Relationship to Patient_____

Sex M F Birth Date_____ Age_____

Employer_____

Occupation _____

SS# _____ NCDL#_____

CONTACT INFORMATION

Home Phone_____ Work Phone_____ Cell Phone_____

E-Mail _____

Emergency Contact (Someone that does not live in your home)

Name_____ Relationship to Patient_____ Phone #_____

HEALTH HISTORY

Physician's Name _____ Preferred Pharmacy _____ Ph#_____

PLEASE CIRCLE YES OR NO BELOW

AIDS/ HIV	YES / NO	Epilepsy	YES / NO	Respiratory Disease	YES / NO
Anemia	YES / NO	Fainting	YES / NO	Rheumatic Fever	YES / NO
Arthritis	YES / NO	Glaucoma	YES / NO	Heart Attack Year_____	YES / NO
Heart Valves	YES / NO	Headaches	YES / NO	Shortness of Breath	YES / NO
Artificial Joints	YES / NO	Heart Murmur	YES / NO	Sinus Trouble	YES / NO
Asthma	YES / NO	Heart Problems	YES / NO	Skin Rash	YES / NO
Back Problems	YES / NO	Hepatitis type_____	YES / NO	Special Diet	YES / NO
Abnormal Bleeding	YES / NO	Herpes	YES / NO	Stroke Year_____	YES / NO
Sickle Cell Disease	YES / NO	High Blood Pressure	YES / NO	Swollen Feet/Ankles	YES / NO
Cancer Type _____		Jaundice	YES / NO	Swollen Neck Glands	YES / NO
Chemotherapy	YES / NO	Jaw Pain	YES / NO	Thyroid Problems	YES / NO
Radiation Treatment	YES / NO	Kidney Disease	YES / NO	Tuberculosis	YES / NO
Emphysema	YES / NO	Liver Disease	YES / NO	Ulcers	YES / NO
Pace Maker	YES / NO	Nervous Problems	YES / NO	Cold Sores	YES / NO
Psychiatric Problems	YES / NO	Mitral Valve Prolapse	YES / NO	Skin Sensitivity	YES / NO
Meningitis	YES / NO	Autism/Sensory	YES/ NO	Intellectual Disabilities	YES/ NO

WOMEN:

Are you pregnant? YES / NO Are you nursing? YES / NO Taking Birth control pills? YES / NO

Due Date_____

LIST MEDICATIONS AND SUPPLEMENTS:

_____

_____

_____

_____

CIRCLE ALLERGIES

Aspirin	Anesthetic	Sulfa
Codeine	Iodine	Penicillin
Clindamycin	Latex	_____

_____

Informed Consent for Dental Treatment

X-rays:

Proposed treatment: taking of intra-oral and extra-oral radiographs. ***Benefits of treatment:*** taking x-rays enables us to view dental cavities, abnormalities, development and eruption of teeth. They are also necessary for proper diagnosis and evaluation purposes. ***Alternatives of treatment:*** none; limited visual examination. ***Common risks:*** radiation exposure to soft and hard tissues. ***Consequences of not performing the treatment:*** missed diagnosis.

Cleaning:

Proposed treatment: involves thorough cleaning of teeth to help heal inflamed or infected gum tissue. It involves removal of *soft* plaque build-up and harder *calculus* deposits above and below the gum line. ***Benefits of treatment:*** healthy oral environment; also , reduction /elimination of bleeding, odor, and periodontal disease. ***Alternatives of treatment:*** referrals for periodontal (gum) surgery according to the severity of condition. ***Common risks:*** bleeding, soreness, swelling, infection of tissue, hot and cold sensitivity, stiff or sore jaw joint. ***Consequences of not performing the treatment:*** discontinued of interrupted treatment could result into further inflammation and infection of gum tissues, lead to more tooth decay, and deterioration of surrounding bone structure which could lead to tooth loss.

Anesthetic:

Proposed treatment: injection of anesthetic to surrounding oral tissues. ***Benefits of treatment:*** numbness of tissue and muscle surrounding area of treatment to eliminate pain sensation. ***Alternatives of treatment:*** dental restorations performed with no anesthetic resulting in severe sensitivity and pain. ***Common risks:*** allergic reaction, irritation to nerve tissue, stiff or sore jaw joint, swelling of tissue, bruising, and may cause temporary or permanent paralysis. ***Consequences of not performing the treatment:*** severe pain and sensitivity.

Fillings:

Proposed treatment: to remove dental caries and replace with filling material to regain proper tooth anatomy. ***Benefits of treatment:*** restore tooth structure for proper function. ***Alternatives of treatment:*** temporary filling, crown, extraction. ***Common risks:*** allergic to filling material, tooth sensitivity, filling may come out. ***Consequences of not performing the treatment:*** further spread of decay, requiring root canal treatment or severe destruction resulting in tooth loss.

Root canal treatment and Pulpotomy:

Proposed treatment: to remove infected pulp tissue and replace with root canal filling material. ***Benefits of treatment:*** eliminate pain, infection, swelling and further destruction of tooth structure. ***Alternatives of treatment:*** extraction. ***Common risks:*** recurrence of symptoms, breakdown of tooth structure. ***Consequences of not performing the treatment:*** increase in severity of pain, swelling, infection, and possible hospitalization and rare instance death.

Crown and bridge:

Proposed treatment: to strengthen a tooth damaged by decay or previous restoration, and protect a tooth that has had root canal treatment. Improve the biting surface, appearance of damaged, discolored, poorly spaced and/or missing teeth. ***Benefits of treatment:*** to restore or improve the appearance and strength of teeth. ***Alternatives of treatment:*** extraction or Orthodontic treatment (only in proper spacing, not damaged teeth). ***Common risks:*** irritation to surrounding tissue, inflammation, irritation to nerve tissue, stiff or sore jaw joint, sensitivity to hot and cold, also possible root canal treatment. ***Consequences of not performing the treatment:*** further destruction, nerve exposure, loss of tooth function, root canal treatment.

Extraction:

Proposed treatment: removal of non-restorable tooth structure and roots. ***Benefits of treatment:*** elimination of pain, infection, swelling. ***Alternatives of treatment:*** none. ***Common risks:*** infection, bleeding, soreness, bruising, damage to adjacent teeth and soft tissue, dry socket, opening into sinuses, tooth and bone fragments, bone fracture, chronic hot and cold sensitivity, temporary and or permanent numbness, and destruction of bone and soft tissue. ***Consequences of not performing the treatment:*** severe pain, swelling, infection, possible hospitalization with rare cases of death.

I have real and understand the entire information on this consent from, which includes x-rays, cleaning, anesthetic, fillings, root canal treatment, pulpotomy, crown, bridge, and extraction. All my questions were answered to my full understanding and satisfaction.

_____ _____

Signature of patient, parent, or legal guardian. **Date**