DENTAL PATIENT MEDICAL HISTORY
COMPLETE IN INK

NAME_____ADDRESS_____

CITY_____STATE_____ZIP_____HOMPHONE_____
DATE OF BIRTH_____SEX(M/F)_____MARITAL STATUS-(S/ M/ D / W) WORK PHONE_____
SSN_____INSURANCE (Y/N)_____EMPLOYER_____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE OR HAVE HAD:

HEART DISEASE OR CONDITION	RHEUMATIC FEVER	ASTHMA	HEPATITIS	VENEREAL DISEASE (SYPHILIIS
ANGINA PECTORIS	STROKE	HAY FEVER	THYROID DISEASE	GONORRHEA)
FREQUENT CHEST PAINS	HEMOPHILA	EMPHYSEMA	GLAUCOMA	DRUG ADDICTION
HIGH BLOOD PRESSURE	BRUISE EASILY	TUBERCULOSIS	EPILESPSY/SEIZURES	PHYCHIATRIC TREATMENT
SHORTNESS OF BREATH	ANEMIA	ULCERS	FAINTING/DIZZINESS	CANCER
SWOLLEN ANKLES	BLOOD TRANSFUSION	KIDNEY TROUBLE	HIV POSITIVE	CHEMOTHERAPY/RADIATION
ARTIFICIAL HEART VALVE	SICKLE CELL DISEASE	LIVER DISEASE	COLD SORES	IMPLANT PROTHESIS
CONGENITAL HEART DISEASE	ARTHRITIS	JAUNDICE	GENITAL HERPES	UNEXPLAINED WEIGHT LOSS
HEART MURMUR	PROLONGED BLEEDING	DIABETES	AIDS	

2. ARE YOU PRESENTLY, OR HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN DURING THE PAST YEAR?	YES	NO
3. ARE YOU PRESENTLY TAKING ANY MEDICINE OR DRUGS?	YES	NO
4. ARE YOU **ALLERGIC** TO ANY MEDICINE OR MATERIALS?	YES	NO
5. HAVE YOU EVER HAD A REACTION TO LOCAL ANESTHETIC?	YES	NO
6. HAVE YOU EVER EXPERIENCED ANY COMPLICATION OR ILLNESS FOLLOWING DENTAL TREATMENT?	YES	NO
7. DO YOU HAVE ANY DISEASES OR CONDITIONS NOT LISTED ABOVE?	YES	NO
8. HAVE YOU EVER BEEN TOLD YOU WERE NOT ELIGIBLE TO BE A BLOOD DONOR?	YES	NO
9. DO YOU USE TOBACCO? FREQUENCY:_____	YES	NO
10.**WOMEN:** ARE YOU PREGNANT? TRIMESTER: 1 2 3	YES	NO

11. WHY ARE YOU HERE TODAY_____

LOCAL ANESTHESIA AND NITROUS OXIDE CONSENT FORM

ALMOST ALL DENTAL PROCEDURES REQUIRE LOCAL ANESTHESIA. THE RISKS INCLUDE, BUT ARE NOT LIMITED TO:

A) THERE ARE RISKS OF ANESTHESIA THAT MAY AFFECT YOUR BODY, SUCH AS DIZZINESS, NAUSEA, VOMITING, ACCELERATED HEART RATE, SLOW HEART RATE, OR VARIOUS TYPES OF ALLERGIC REACTIONS. ANY OR ALL OF THESE MAY REQUIRE ADDITIONAL MEDICAL MANAGEMENT OR HOSPITALIZATION.

B) RESTRICTED MOUTH OPENING DURING RECOVERY, SOMETIMES RELATED TO MUSCLE SORENESS AT THE SITE OF THE INJECTION REQUIRING PHYSICAL THERAPY.

C) LOCAL ANESTHESIA MAY CAUSE PROLONGED NUMBNESS, THAT IN SOME PATIENTS MAY RESULT IN INJURY FROM BITING OR CHEWING IN AN AREA SUCH AS (LIP, CHEEK OR TONGUE) THAT HAS RECEIVED THE LOCAL ANESTHESIA

D) INJURY TO NERVES THAT CAN RESULT IN PAIN, NUMBNESS, TINGLING OR OTHER SENSORY DISTURBANCES TO THE CHIN, LIP, CHEEK, GUMS, OR TONGUE. THIS MAY PERSIST FOR SEVERAL WEEKS, MONTHS, OR RARELY, BE PERMANENT

E) LOCAL ANESTHIA IS ADMINISTERED WITH A VERY SMALL FINE NEEDLE. IN VERY RARE INSTANCES THESE NEEDLES MAY BREAK OFF AND BE LODGED IN SOFT TISSUE.

F)IF YOU ARE PREGNANT OR THINK YOU MAY BE, YOU SHOULD NOT USE NITROUS OXIDE.

PLEASE ASK THE DENTIST IF YOU HAVE ANY QUESTIONS REGARDING THIS CONSENT FORM. DO NOT INITIAL OR SIGN ANY BLANK IF YOU HAVE NOT HAD YOUR QUESTIONS ANSWERED.
I HEREBY ACKNOWLEDGE THAT I HAVE READ THIS DOCUMENT, AND HAVE DISCUSSED ALL QUESTIONS OR CONCERNS THAT I MIGHT HAVE REGARDING LOCAL ANESTHESIA

_____ _____
PATIENT OR GUARDIAN SIGNATURE DATE

_____ _____
WITNESS SIGNATURE DATE

DENTIST'S COMMENTS:

BLOOD PRESSURE / DATE BLOOD PRESSURE / DATE BLOOD PRESSURE / DATE BLOOD PRESSURE / DATE

DENTIST'S SIGNATURE DATE REVIEWED REVIEWED REVIEWED REVIEWED REVIEWED REVIEWED REVIEWED

INFORMED CONSENT FOR SURGERY(Including Extractions, Periodontal surgery(gum surgery) and any dental surgery): This is my informed consent, authorization and request for the oral surgery mutually deemed necessary or advisable and any other oral surgery deemed necessary or advisable as a corollary to the planned operation.

I also consent to, authorize, and request the use of such intravenous sedatives, local or general anesthetics and drugs as may be deemed advisable depending upon the judgment of the doctor(s) involved in my case. Complaints which may result from surgery of the type, of which I am herewith advised include:

A. Possible anesthesia of one or both lingual nerves (tongue) and/or inferior alveolar nerves (lower lip).
B. Possible involvement of the maxillary sinuses that might require further surgery.
C. Possible fracture of the jaw in the area of the impacted wisdom teeth that will require additional surgical procedures.
D. Possible fracture of adjacent teeth or their restorations that will require further therapy by a general dentist.
E. Possible pain, swelling, bruising, nausea and vomiting, post-operative infection, delayed healing, phlebitis, unfavorable reaction to drugs and/or anesthetics.

I have read the above which has also been explained to me, and I am willing to accept the services as offered by the doctor(s) involved in my treatment believing that everything will be done to fully benefit me and that every precaution will be exercised to prevent complications in any way.

PATIENT
SIGNATURE_____DATE_____

(PARENT IF MINOR)

WITNESS
SIGNATURE_____DATE_____

INFORMED CONSENT FOR ROOT CANAL TREATMENT: I understand that Root Canal treatment is a procedure to retain a tooth which may otherwise require extraction. Although Root Canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Occasionally a tooth which has had Root Canal therapy may require retreatment, surgery, or even extraction. I also understand that the permanent outside restoration (crown) will need to be done. Although rare, the following complications may occur in endodontic therapy: pain and swelling, damage to an existing crown or filling, fracture of a root, fracture of a fine instrument in root canal, overfill, underfill, or perforation of a root

PATIENT
SIGNATURE_____DATE_____

(PARENT IF MINOR)

WITNESS
SIGNATURE_____DATE_____