PERSONAL INFORMATION

Today's date _____

Email _____

First name _____ Middle Initial _____ Last Name _____

I prefer to be called _____ Male _____ Female _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security # _____

Cell Phone _____

Do we have permission to text you? Yes _____ No _____

Work Phone _____ Home Phone _____

Primary contact number (Check one) Cell _____ Work _____ Home _____

Employer _____

Spouses's Name _____ Spouse's Employer _____

Whom may we thank for referring you? _____

Emergency contact person / contact number _____

MEDICAL HISTORY

PATIEN'S NAME _____ BIRTH DATE _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication 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?	O Yes	O No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	O Yes	O No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	O Yes	O No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	O Yes	O No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	O Yes	O No	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	O Yes	O No	_____
Are you on a special diet?	O Yes	O No	_____
Do you use tobacco?	O Yes	O No	
Do you use controlled substances?	O Yes	O No	_____

WOMEN:
Are you Pregnant/Trying to get pregnant? O Yes O No Taking oral contraceptives? O Yes O No Nursing? O Yes O No

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

AIDS/HIV Positive	O Yes	O No
Alzheimer's Disease	O Yes	O No
Anemia Angina	O Yes	O No
Artificial Heart Valve	O Yes	O No
Artificial Joint	O Yes	O No
Asthma	O Yes	O No
Blood Disease	O Yes	O No
Blood Transfusion	O Yes	O No
Arthritis/Gout	O Yes	O No

Breathing Problem	O Yes	O No
Bruise Easily	O Yes	O No
Cancer	O Yes	O No
Chemotherapy	O Yes	O No
Chest Pains	O Yes	O No
Cold Sores/Fever Blister	O Yes	O No
Congenital Heart Disorder	O Yes	O No
Convulsions	O Yes	O No
Drug Addiction	O Yes	O No

Cortisone Medicine	O Yes	O No
Diabetes	O Yes	O No
Easily Winded	O Yes	O No
Emphysema	O Yes	O No
Epilepsy or Seizures	O Yes	O No
Excessive Bleeding	O Yes	O No
Excessive Thirst	O Yes	O No
Fainting Spells/Dizziness	O Yes	O No
Frequent Cough	O Yes	O No

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

Frequent Diarrhea	O Yes	O No
Frequent Headaches	O Yes	O No
Genital Herpes	O Yes	O No
Glaucoma	O Yes	O No
Hay Fever	O Yes	O No
Heart Attack/Failure	O Yes	O No
Heart Murmur	O Yes	O No
Heart Pacemaker	O Yes	O No
Heart Trouble/Disease	O Yes	O No
Hemophilia	O Yes	O No
Hepatitis A	O Yes	O No
Hepatitis B or C	O Yes	O No
Herpes	O Yes	O No
High Blood Pressure	O Yes	O No
High Cholesterol	O Yes	O No
Hives or Rash	O Yes	O No

Hypoglycemia	O Yes	O No
Irregular Heartbeat	O Yes	O No
Kidney Problems	O Yes	O No
Leukemia	O Yes	O No
Liver Disease	O Yes	O No
Low Blood Pressure	O Yes	O No
Lung Disease	O Yes	O No
Mitral Valve Prolapse	O Yes	O No
Osteoporosis	O Yes	O No
Pain in Jaw Joints	O Yes	O No
Parathyroid Disease	O Yes	O No
Psychiatric Care	O Yes	O No
Radiation Treatments	O Yes	O No
Recent Weight Loss	O Yes	O No
Renal Dialysis	O Yes	O No
Rheumatic Fever	O Yes	O No

Rheumatism	O Yes	O No
Scarlet Fever	O Yes	O No
Shingles	O Yes	O No
Sickle Cell Disease	O Yes	O No
Sinus Trouble	O Yes	O No
Spina Bifida	O Yes	O No
Stomach/Intestinal Disease	O Yes	O No
Stroke	O Yes	O No
Swelling of Limbs	O Yes	O No
Thyroid Disease	O Yes	O No
Tonsillitis	O Yes	O No
Tuberculosis	O Yes	O No
Tumors or Growths	O Yes	O No
Ulcers	O Yes	O No
Venereal Disease	O Yes	O No
Yellow Jaundice	O Yes	O No

Have you ever had any serious illness not listed above? O Yes O No _____

Are you allergic to any of the following?

O Aspirin O Penicillin O Codeine O Local Anesthetics O Acrylic O Metal O Latex O Sulfa Drugs

O Other If yes, please explain: _____

Comment: _____

_____

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, or GUARDIAN _____ DATE _____

NAME OF PATIENT, PARENT, or GUARDIAN (Print) _____

WITNESS SIGNATURE _____ DATE _____

DR. SIGNATURE _____ DATE _____

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DENTAL STUDIO

INFORMED TREATMENT CONSENT AND PERMISSION FORM

LOCAL ANESTHESIA

THIS CONSENT FORM IS DESIGNED TO MAKE YOU AWARE OF THE RISKS INVOLVED WITH LOCAL ANESTHESIA. THE RISKS INCLUDE, BUT ARE NOT LIMITED TO:

- THERE ARE RISKS OF ANESTHESIA THAT MAY AFFECT YOUR BODY, SUCH AS DIZZINESS, NAUSEA, VOMITING, ACCELERATED.
- RESTRICTED MOUTH OPENING DURING RECOVERY, SOMETIMES RELATED TO MUSCLE SORENESS AT THE SITE OF THE INJECTION REQUIRING PHYSICAL THERAPY.
- LOCAL ANESTHESIA MAY CAUSE PROLONGED NUMBNESS THAT IN SOME PATIENTS MAY RESULT IN INJURY FROM BITING OR CHEWING AN AREA SUCH AS (LIP, CHEEK OR TONGUE) THAT HAS RECEIVED THE LOCAL ANESTHESIA.
- 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.
- LOCAL ANESTHESIA IS ADMINISTERED WITH A VERY SMALL FINE NEEDLE. IN VERY RARE INSTANCES THESE NEEDLES MAY BREAK OFF AND BE LODGED IN SOFT TISSUE.

PLEASE ASK OUR 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.

EMAIL _____

PATIENT / PARENT PRINTED NAME _____

PATIENT / PARENT SIGNATURE _____ DATE _____

WITNESS NAME & SIGNATURE _____ DATE _____