

## Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

### 1. Treatment to be provided

I understand that during my course of treatment that the following care may be provided:

Examinations \_\_\_\_\_ Preventive Services \_\_\_\_\_ Restorations \_\_\_\_\_  
Crowns \_\_\_\_\_ Bridges \_\_\_\_\_ Other \_\_\_\_\_ Patient Initials \_\_\_\_\_

### 2. Drugs and Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Patient Initials \_\_\_\_\_

### 3. Changes in Treatment Plan

I understand that during treatment 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. Patient Initials \_\_\_\_\_

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. Patient Initials \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**PATIENT REGISTRATION**

ID: \_\_\_\_\_ Chart ID: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Patient Is:  Policy Holder Preferred Name: \_\_\_\_\_  
 Responsible Party

Responsible Party (if someone other than the patient)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

Responsible Party is also a Policy Holder for Patient  Primary Insurance Policy Holder  Secondary Insurance Policy Holder

Patient Information

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State / Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

E-mail: \_\_\_\_\_  I would like to receive correspondences via e-mail.

Section 2

Section 3

Employment Status:  Full Time  Part Time  Retired

Additional Comments:

Student Status:  Full Time  Part Time

Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_

Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_

Carrier ID: \_\_\_\_\_ Pref. Hyg.: \_\_\_\_\_

Primary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Rem. Benefits: .00 Rem. Deduct: .00

Patient Name:

Birth Date:

Date Created:

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?  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 injury?  Yes  No

If yes

Are you taking any medications, pills, or drugs?  Yes  No

If yes

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No

If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No

If yes

Are you on a special diet?  Yes  No

Do 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  
 Metal

Penicillin  
 Latex

Codeine  
 Sulfa Drugs

Acrylic  
 Local Anesthetics

Do you use controlled substances?  Yes  No

If yes

Other?

If yes

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

- AIDS/HIV Positive  Yes  No
- Alzheimer's Disease  Yes  No
- Anaphylaxis  Yes  No
- Anemia  Yes  No
- Angina  Yes  No
- Arthritis/Gout  Yes  No
- Artificial Heart Valve  Yes  No
- Artificial Joint  Yes  No
- Asthma  Yes  No
- Blood Disease  Yes  No
- Blood Transfusion  Yes  No
- Breathing Problems  Yes  No
- Bruise Easily  Yes  No
- Cancer  Yes  No
- Chemotherapy  Yes  No
- Chest Pains  Yes  No
- Cold Sores/Fever Blisters  Yes  No
- Congenital Heart Disorder  Yes  No
- Convulsions  Yes  No
- Yellow Jaundice  Yes  No

- Cortisone Medicine  Yes  No
- Diabetes  Yes  No
- Drug Addiction  Yes  No
- Easily Winded  Yes  No
- Emphysema  Yes  No
- Epilepsy or Seizures  Yes  No
- Excessive Bleeding  Yes  No
- Excessive Thirst  Yes  No
- Fainting Spells/Dizziness  Yes  No
- Frequent Cough  Yes  No
- Frequent Diarrhea  Yes  No
- Frequent Headaches  Yes  No
- Genital Herpes  Yes  No
- Glaucoma  Yes  No
- Hay Fever  Yes  No
- Heart Attack/Failure  Yes  No
- Heart Murmur  Yes  No
- Heart Pacemaker  Yes  No
- Heart Trouble/Disease  Yes  No

- Hemophilia  Yes  No
- Hepatitis A  Yes  No
- Hepatitis B or C  Yes  No
- Herpes  Yes  No
- High Blood Pressure  Yes  No
- High Cholesterol  Yes  No
- Hives or Rash  Yes  No
- Hypoglycemia  Yes  No
- Irregular Heartbeat  Yes  No
- Kidney Problems  Yes  No
- Leukemia  Yes  No
- Liver Disease  Yes  No
- Low Blood Pressure  Yes  No
- Lung Disease  Yes  No
- Mitral Valve Prolapse  Yes  No
- Osteoporosis  Yes  No
- Pain in Jaw Joints  Yes  No
- Parathyroid Disease  Yes  No
- Psychiatric Care  Yes  No

- Radiation Treatments  Yes  No
- Recent Weight Loss  Yes  No
- Renal Dialysis  Yes  No
- Rheumatic Fever  Yes  No
- Rheumatism  Yes  No
- Scarlet Fever  Yes  No
- Shingles  Yes  No
- Sickle Cell Disease  Yes  No
- Sinus Trouble  Yes  No
- Spina Bifida  Yes  No
- Stomach/Intestinal Disease  Yes  No
- Stroke  Yes  No
- Swelling of Limbs  Yes  No
- Thyroid Disease  Yes  No
- Tonsillitis  Yes  No
- Tuberculosis  Yes  No
- Tumors or Growths  Yes  No
- Ulcers  Yes  No
- Venereal Disease  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 or Guardian:

X

Date: \_\_\_\_\_