A'DENTISTRY
GENERAL HEALTH INFORMATION

CHART # _____

DATE: _____

PATIENT NAME: _____ BIRTH DATE: _____ AGE: _____
LAST FIRST

DENTAL HISTORY

1. Are there other conditions of which we should be aware? YES _____ NO _____ If yes, please specify: _____
2. Why are you here today? Check-Up _____ Cleaning _____ Other _____
   Toothache _____ Chief Complaint _____
3. When did you last visit a dentist? _____ 4. What treatment was performed? _____
5. Was the treatment completed? _____ 6. Did you have a cleaning? _____
7. When were dental x-rays taken? _____
8. Have you ever had prolonged bleeding after an extraction? YES ____ NO ____ If yes, please specify: _____
9. Have you had any problems with past dental treatment? YES ____ NO ____ If yes, please specify: _____
10. Do you have symptoms near your ears associated with movement of your lower jaw such as clicking, popping, pain or locking open?
    YES ____ NO ____ If yes, please specify: _____
11. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction sometimes called TMJ)?
    YES ____ NO ____ If yes, please specify: _____
12. Do your gums bleed easily? YES ____ NO ____ 13. Do you feel you have bad breath? YES ____ NO ____
14. Are your teeth sensitive to hot or cold? YES ____ NO ____ 15. Would you like your teeth whiter? YES ____ NO ____
16. Are there any cosmetic changes you would like to have done on your teeth? YES ____ If yes, please specify: _____

MEDICAL HISTORY

1. Are you under a Doctor's care at this time? YES ____ NO ____ If yes, please specify: Dr. Name: _____
   Dr. Ph # ( ) _____
2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine? _____
3. Are you taking any medications at this time, including birth control? YES ____ NO ____ If yes, please specify: _____
4. (Woman) Are you pregnant at this time? YES ____ NO ____ if yes, please specify how many months: _____
5. Are there any other health problems of which we should be advised? Please specify: _____
6. Do you have, or have you had, any of the following?

Please check "YES" or "NO"		Doctor Comments	Please check "YES" or "NO"		Doctor Comments
ARTIFICIAL Heart valve	YES ☐ NO ☐		HEPATITIS	YES ☐ NO ☐	
AIDS/HIV+	YES ☐ NO ☐		HIGH BL.PRESSURE	YES ☐ NO ☐	
ANEMIA	YES ☐ NO ☐		JAUNDICE	YES ☐ NO ☐	
ANGINA	YES ☐ NO ☐		JOINT PROSTHESIS	YES ☐ NO ☐	
ARTHRITIS	YES ☐ NO ☐		KIDNEY DISEASE	YES ☐ NO ☐	
ASTHMA	YES ☐ NO ☐		LATEX ALLERGY	YES ☐ NO ☐	
BLEEDING PROBLEMS	YES ☐ NO ☐		LIVER PROBLEMS	YES ☐ NO ☐	
CANCER	YES ☐ NO ☐		LOW BL.PRESSURE	YES ☐ NO ☐	
CHEMO/RAD THERAPY	YES ☐ NO ☐		LUNG DISEASE	YES ☐ NO ☐	
COSMETIC SURGERY	YES ☐ NO ☐		PACEMAKER	YES ☐ NO ☐	
DIABETES	YES ☐ NO ☐		PHEN-FEN	YES ☐ NO ☐	
DIZZY SPELLS	YES ☐ NO ☐		PSYCHIATRIC CARE	YES ☐ NO ☐	
DRUG ADDICTION	YES ☐ NO ☐		RHEUMATIC FEVER	YES ☐ NO ☐	
EMPHYSEMA	YES ☐ NO ☐		SINUS TROUBLE	YES ☐ NO ☐	
EPILEPSY	YES ☐ NO ☐		SMOKING TOBACCO	YES ☐ NO ☐	
FAINTING	YES ☐ NO ☐		STROKE	YES ☐ NO ☐	
GLAUCOMA	YES ☐ NO ☐		THYROID PROBLEMS	YES ☐ NO ☐	
HEART ATTACK	YES ☐ NO ☐		TMD OR TMJ	YES ☐ NO ☐	
HEART SURGERY	YES ☐ NO ☐		TUBERCULOSIS	YES ☐ NO ☐	
HEART MURMUR	YES ☐ NO ☐		VENEREAL DISEASE	YES ☐ NO ☐	
HEART PROBLEMS	YES ☐ NO ☐				

To the best of my knowlege, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to the performing of x-rays and oral examination.

Patient's signature _____ Date _____
(or Parent if patient is a minor)

Doctor Signature _____

RECALL REVIEW:

1. Patient's signature _____ Doctor's Signature _____ Date _____
2. Patient's signature _____ Doctor's Signature _____ Date _____
3. Patient's signature _____ Doctor's Signature _____ Date _____

A' DENTISTRY

PATIENT INFORMATION

CHART # _____

PATIENT

Name _____
Last First

Address _____ Apt. # _____

City _____ Zip _____

How long at this address ?

Phone ( ) _____ Cellular Pager ( ) _____

E-mail _____

Social Security # _____ DL.# _____

Age _____ Birthdate _____

PERSON TO CONTACT FOR EMERGENCY:

_____
Last First

_____
Address

City _____ Zip _____

Tel. # ( ) _____

Physician Name _____

Tel. # ( ) _____

RESPONSIBLE PARTY (If same as above, please skip)

Name _____
Last First

Address _____ Apt. # _____

City _____ Zip _____

How long at this address ?

Phone ( ) _____

Social Security # _____

Relationship to Patient _____

Age _____ Birthdate _____

GETTING TO KNOW YOU

Are there other members of your household who are not patients at our office?

YES__ NO__ Please list names & relationship (son,daughter,husband) below:

1: _____ 2: _____

3: _____ 4: _____

How did you hear of us? _____

_____

Are you or anyone in your family a Union member ? ___YES ___NO

If yes, specify Union/Local: _____

I want information in Spanish: ___YES ___NO

EMPLOYMENT

Occupation _____

Employer _____

How long ? _____

Business address _____

City _____ Zip _____

Business Phone ( ) _____ Ext. # _____

Verified By _____ Date _____
(Office use only)

1. I hereby certify that the above information is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid for by my insurance for whatever reason.
2. By signing below, I understand that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.
3. I hereby authorize payment directly to the dentists of the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.
4. I acknowledged that each dentist is individually responsible for the dental care provided to me and no other dentist nor A' DENTISTRY is responsible for my dental treatment.

_____
Signature of responsible party or patient (Parent if patient is a minor) Date

A'DENTISTRY GENERAL DENTISTRY INFORMED CONSENT

CHART #_____

All patients complete 1 thru 4 below, and 5 thru 10 as needed

1. EXAMINATIONS AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan.

2. DRUGS. MEDICATIONS. AND SEDATION (*Initials*_____)

I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction) They may cause drowsiness and lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives. (*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. (*Initials*_____)

4. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)

I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility. (Initials_____)

5. FILLINGS

I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of a newly placed filling. (*Initials*_____)

6. 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 not 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 (Parasthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. (*Initials*_____)

7. CROWNS. BRIDGES. CAPS. VENEERS AND BONDING

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 that the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. It has been explained to me that, in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. (*Initials*_____)

8. DENTURES - COMPLETE OR PARTIAL

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

9. 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*_____)

10. PERIODONTAL TREATMENT

I understand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery, and/or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, follow a healthy diet, avoid tobacco products and follow other recommendations. (*Initials*_____)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly 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 understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than the treating Dentist nor A'DENTISTRY is responsible for my dental treatment. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

Signature: _____ Date: _____

Doctor: _____ Witness: _____