HEALTH HISTORY

Name _____ Date _____

Date of last health care exam: _____ What was this exam for? _____

Have you been hospitalized or had surgery? (Please circle) No Yes

If yes, reason: _____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Blood Disorders?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma, COPD or other Lung Diseases	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychiatric Therapy	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Renal Dialysis	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery, Angina	No	Yes	Other Conditions	No	Yes
Heart Stent? When placed?	No	Yes	Recurrent Illnesses	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Biaxin® (clarithromycin)	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Barbiturates (any)	No	Yes
Dilantin® or Tegretol®	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®, RECLAST) or PROLIA? If so, when did the treatment begin? When did the treatment end?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Please list any medications you are currently taking and dosages:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

Please list any dietary or herbal supplements you are taking, and for what purpose:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Do you use recreational drugs? ____ If so, which ones? _____

Sleep:

1. Do you suspect or have you been told that you snore?
2. Do you suspect or have you been diagnosed with sleep apnea?
3. Are you being treated for sleep apnea with a CPAP, BiPAP, or other device?

Women: Are you pregnant? No Yes
If no, are you planning a pregnancy in the near future? No Yes
Are you a nursing mother? No Yes
Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes
Have you ever received a diagnosis of "high blood pressure" or "low blood pressure"?
What is your normal blood pressure? S /D Today: _____/_____

Are you allergic or have you had a reaction to:

a. Local anesthetics or epinephrine..... No Yes
b. Penicillin or other antibiotics ..... No Yes
c. Aspirin, Ibuprofen or Tylenol® ..... No Yes
d. Codeine, Valium®, Hydrocodone, Oxycodone or other sedatives..... No Yes
e. Latex or Metals
f. Other (please specify)_____

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

Weight and Diet considerations

Weight	Height	Meals per Day	Dietary Restrictions	Food Allergies
Sugar in your diet (circle one): *none slight moderate high*				

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

Significant findings from questionnaire or oral interview:

Dental management considerations:

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Patient (Print Name) *Patient Signature* *Date*

Doctor (Print Name) *Doctor Signature* *Date*

ORAL CONSCIOUS (MINIMAL or MODERATE ORAL) SEDATION ("OCS")
INFORMED CONSENT FORM

The purpose of this document is to provide an opportunity for patients to understand and give permission for oral conscious (minimal or moderate oral) sedation ("OCS") when provided along with dental treatment. Each item should be checked off after the patient has the opportunity for discussion and questions.

_____ 1. I understand that the purpose of OCS is to more comfortably receive necessary care. OCS is not required to provide the necessary dental care. I understand that OCS has limitations and risks and absolute success cannot be guaranteed. (See #4 options.)

_____ 2. I understand that OCS is a drug-induced state of reduced awareness and decreased ability to respond. OCS is not sleep. I will be able to respond during the procedure. My ability to respond normally returns when the effects of the sedative wear off.

_____ 3. I understand that my OCS will be achieved by the following route:

_____ Oral Administration: I will take a sedative(s) approximately _____ minutes before (and possibly again during) my appointment. The sedation will last approximately _____ to _____ hours.

_____ 4. I understand that the alternatives to OCS are:

_____ a. No sedation: The necessary procedure is performed under local anesthetic with the patient fully aware.

_____ b. Nitrous oxide sedation: Commonly called laughing gas, nitrous oxide provides relaxation but the patient is still generally aware of surrounding activities. Its effects can be reversed in five minutes with oxygen.

_____ c. Anxiolysis (or minimal) sedation: A pharmacologically induced state of consciousness where an individual is awake but has decreased anxiety to facilitate coping skills, retaining interactive ability.

_____ d. Oral conscious (minimal or moderate oral) sedation: Sedation via pill form that will put me in a minimally to moderately depressed level of consciousness.

_____ e. Intravenous (I.V.) conscious (or moderate) sedation: The doctor could inject the sedative in a tube connected to a vein in my arm to put me in a minimally to moderately depressed level of consciousness.

_____ f. General anesthesia: Also called deep sedation, a patient under general anesthetic has no awareness and must have their breathing temporarily supported. General anesthesia is more appropriate for longer procedures lasting 3 or more hours.

_____ 5. I understand that there are risks or limitations to all procedures. For sedation these include:

_____ (oral sedation) Inadequate sedation with initial dosage may require the patient to undergo the procedure without full sedation or delay the procedure for another time. Likewise, in compliance with state regulations, an additional dose or doses may be required to complete the procedure.

_____ Atypical reaction to sedative drugs that may require emergency medical attention and/or hospitalization such as altered mental states, physical reactions, allergic reactions, and other sicknesses.

_____ Inability to discuss treatment options with the doctor should circumstance requires a change in treatment plan.

_____ 6. If, during the procedure, a change in treatment is required, *including abandoning the original treatment plan if medically/professionally necessary*, I authorize the doctor and the operative team to make whatever change they deem in their professional judgment is necessary. I understand that I have the right to designate the individual who will make such a decision.

_____ 7. I have had the opportunity to discuss OCS and have my questions answered by qualified personnel including the doctor. I also understand that I must follow all the recommended treatments and instructions of my doctor.

_____ 8. I understand that I must notify the doctor if I am pregnant, or if I am lactating. I must notify the doctor if I have sensitivity to any medication, of my present mental and physical condition, if I have recently consumed alcohol, and if I am presently on psychiatric mood altering drugs or other medications.

_____ 9. I will not be able to drive or operate machinery while taking oral sedatives for 24 hours after my procedure. I understand I will need to have arrangements for someone to drive me to and from my dental appointment while taking oral sedatives.

_____ 10. I hereby consent to OCS in conjunction with my dental care.

_____ _____ _____
Patient / Guardian Date Witness

Prior to Sedation Visit

Date: _____

Patient: _____ Gender: ____ Medical Status: ASA I II III

(*circle one*) Age: _____ Height: _____ Weight: _____ lbs._____kg. (*lb/2.2*) BMI: _____

Allergies (drug & food): _____

Pre-medication for _____ Ab_____dose: _____ time:_____

Diet habits: Eats/snacks every ____hours. Usual bathroom routine: _____

Dietary notes & amount of sugar in diet: _____

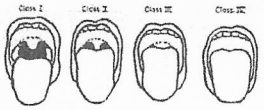
Can we give your post op instructions to your driver? _____*(patient initials)*

Alcohol consumer in a week _____ Recreational drugs (& how often):_____

Normal daily medications (& dosage):_____

Did you take them? Y/N_____*(patient initials)* ❑ LexiComp compared and in chart.

Smoker (how much) _____ Gagger*(circle)*



Baseline Pulse _____ Sa O2: _____% BP: _____/_____

Respiratory Rate (pre-op) _____(breaths/min) Mallampatti Classification

Premed Rx _____(daiz, triaz, loraz) Specific Instructions: _____

List current dental needs:_____

On a scale of 1- 10 how anxious are you about the dental visit?_____

Do you have a history with sedation? _____

What are your expectations of the sedation visit? _____

Day of Treatment

Last food or water other than medications: _____date _____ time

Medication	Time	Route	Dosage	Medication	Time	Route	Dosage

TOP Dose =_____ Pt. Wgt/QF (QF triazolam = 100 QF lorazepam = 25)

2% Mepivacaine 1:20,000 Neo:_____

3% Mepivacaine _____

2% Lidocaine with 1:100,000 epi:_____

3% Polocaine _____

4% Septocaine w/1:100K epi:_____

4% Citanest plain: _____

PATIENT NUMBER

PATIENT'S NAME _____
Last First Initial Date of Birth

I hereby authorize _____
DOCTOR'S NAME

and whomever he/she may designate as his/her assistants, to perform upon me the following operation and/or procedures:

I request and authorize him/her to do whatever he/she deems advisable if any unforeseen condition arises in the course of these designated operations and/or procedures calling, in their judgment, for procedures in addition to or different from those now contemplated.

I consent to the above treatment after having been advised of the risks, advantages and disadvantages of the treatments and the consequences if this treatment were withheld.

I consent to the above treatment plan after having been advised of the alternate plans of treatment available and the known material risks, advantages and disadvantages of the alternative treatment.

I further consent to the administration of local or general anesthesia, antibiotics, analgesics, nitrous oxide or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug response (e.g., allergic reactions), cardiac arrest, and aspiration, and thrombophlebitis (e.g. irritation and swelling of a vein), pain, discoloration and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications include post-operative bleeding, swelling or bruising, discomfort, stiff jaws, loss or loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbances (e.g., numbness in mouth and lip tissues), jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, and small root fragments remaining in the jaw which might require extensive surgery for removal.

I realize that in spite of the possible complications and risks, my contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

I have provided as accurate and complete a medical and personal history as possible including those antibiotics, drugs, medications and foods to which I am allergic. I will follow any and all instructions as explained and directed to me and permit prescribed diagnostic procedures.

I have had the opportunity to ask questions and receive answers to and responsive explanations for, all questions about my medical condition, contemplated and alternative treatment and procedures, and the risk and potential complications of the contemplated and alternative treatments and procedures, prior to signing this form.

Patient or Guardian's Signature _____ Date _____

Dentist's Signature _____ Date _____

Witness's Signature _____ Date _____

Form No. T243CF

CONSENT FORM