

Patient's Name
Patient's Account No.

DENTAL HISTORY

Medical Alert

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____
 What was done at your last dental visit? _____

Previous Dentist's Name _____
 Address _____ State _____ Zip _____
 Telephone _____

How often do you have dental examinations? _____
 How often do you brush your teeth? _____ How often do you floss? _____
 What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No
 If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No

Have you noticed any mouth odors or bad tastes? Yes No
 Do you frequently get cold sores, blisters or any other oral lesions: Yes No
 Do your gums bleed or hurt? Yes No
 Have your parents experienced gum disease or tooth loss? Yes No
 Have you noticed any loose teeth or change in your bite? Yes No
 Does food tend to become caught in between your teeth: Yes No
 If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (Pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (Joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing or either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance? Yes No
 Would you like to keep all your teeth all you life? Yes No

Do you feel nervous about having dental treatment? Yes No
 If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience? Yes No
 If yes, please describe _____

Is there anything else about have dental treatment that you would like us to know? Yes No
 If yes, please describe _____

INFORMED CONSENT

Name _____ Date _____

1. **Work to be Done:**

I understand that I am having the following work done: Fillings _____ Bridge _____ Crowns _____ Extractions _____
Impacted teeth removed _____ IV Sedation _____ Root Canals _____ Other _____ Initials _____

2. **Drugs and Medications:**

I 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). 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, after having been informed and in agreement with the changes. Initials _____

4. **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 involve 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 (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment. Initials _____

5. **Anesthesia:**

I realize that risks involved in receiving an anesthetic, some of which are: upset stomach, dizziness, vomiting, sore arm, inflamed vessels of the area. Adverse reactions to the drugs causing cardiac arrest, miscarriage, dislodging or chipping teeth and jaw bone. Initials _____

6. **Crowns, Bridges and Caps:**

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 crown, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. Initials _____

7. **Dentures - Complete or Partial:**

I realize that full or partial dentures are artificial, constructed of plastic, metal, and or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage, and relining due to tissue change. Initials _____

8. **Endodontic Treatment (Root Canal):**

I realize there is not guarantee that root canal treatment will save my tooth and that complication can occur from the treatment ant that occasionally metal objects are cemented to the tooth or extended through the root which does not necessarily affect the success of the treatment. Initials _____

9. **Periodontal Loss (Tissue and Bone):**

I understand that I have a serious condition causing gum and bone inflammation or loss and that it can lead to the loss of my teeth and other complications. The alternative treatment plans have been explained to me including, gum surgery, replacements and or extractions. I understand that although these treatments have a high degree of success, it cannot be guaranteed. Occasionally, treated teeth may require extraction. Initials _____

10. **Fillings:**

I have been advised by the Dentist that the silver amalgam restoration is an acceptable procedure according to ADA guidelines and, as such, is a treatment used by Excel Dental. The advantages and disadvantages of alternative materials have been explained to me. Initials _____

I hereby request and authorize the Dentists and their Staff to perform dental work upon me for the purpose of attempting to improve my appearance, function and the health of my mouth, teeth, bone and tissue, as explained above.

The effect and nature of the proceeding to be performed, and the risks involved, as well as the possible alternative methods of treatment have been fully explained to me.

I also authorize the operating Dentist and Assistants to perform any other procedure which they may deem necessary or desirable in attempting to improve the condition stated on the diagnostic treatment form, or treat unhealthy or unforeseen conditions that may be encountered during the operation.

I know that the practice of Dentistry and surgery 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 treatment which I have requested and authorized.

I also understand that it is my responsibility to inform the Dintist if I amy having any problems during the following treatment so as to allow him to help minimize the problems.

Alternative and possible reactions have been explained to me clearly and in detail. Complications, such as infection, hemorrhage and or bleeding, scarring, contraction, possible deformities, prolonged healing time over the estimated, reaction to any drugs before, during and after surgery, numbness or itching of the tongue, lip, teeth, tissues, fractured jaw, etc., Have been clearly explained to me.

I CERTIFY THAT I HAVE BEEN AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE, ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

Signature _____ Relationship _____ Date _____

Doctor _____ Witness _____ Date _____