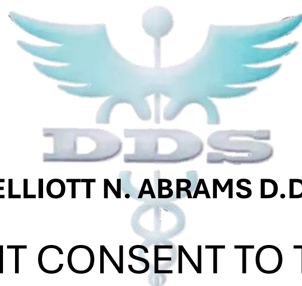

Name: ___________

____

ELLIOTT N. ABRAMS D.D.S

PATIENT CONSENT TO TREATMENT

In reading and signing this form it is understood that ENGLISH is the language that I understand and use to communicate.

(Initials) _____

1. DRUGS, MEDICATIONS, AND ANESTHESIA:

I understand that antibiotics, analgesics, and other medications may cause adverse reactions, some of which are, but are not limited to, redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest.

I understand that medications, drugs, and anesthetics may cause drowsiness and lack of coordination, which can be increased using alcohol or other drugs. I have been advised not to consume alcohol, nor operate any vehicle or hazardous device while taking medications and/or drugs, or until fully recovered from their effects (this includes a period of at least twenty- four [24] hours after my release from surgery).

I understand that occasionally, upon injection of a local anesthetic, I may have prolonged, persistent anesthesia, numbness. and/or irritation to the area of injection. I understand that if select to utilize Nitrous Oxide, "Atarax", Chloryl hydrate, "Zanax", or any other sedative, possible risks include, but are not limited to, loss of consciousness, obstruction of airway, anaphylactic shock, cardiac arrest.

I understand that someone needs to drive me home from the dental office after I have received sedation. I also understand that someone needs to watch me closely for a period of 8ot lo hours, following my dental appointment, to observe for possible deleterious side effects, such as obstruction of airway.

(Initials) _____

2. HYGIENE AND PERIODONTICS (TISSUE AND BONE LOSS):

I understand that the long-term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e. brushing and flossing) and maintaining regular recall visits.

(Initials)_____

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

(Initials)_____

3. REMOVAL OF TEETH:

I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably worsen in time. Potential risks include, but are not limited to, the following:

A. Post-operative discomfort; swelling; prolonged bleeding; tooth sensitivity to hot or cold; gum shrinkage (possibly exposing crown margins); tooth looseness; delayed healing (dry socket) and/or infection (requiring prescriptions or additional treatment, i.e. surgery).
B. Injury to adjacent teeth, caps, or fillings (requiring the recommendation of crowns, replacement of fillings, fabrication of crowns, or extraction), or injury to other tissues not within the described surgical area.
C. Limitation of opening; stiffness of facial and/or neck muscles; change in bite; or temporomandibular joint (jaw joint) difficulty (possibly requiring physical therapy or surgery).

D. Residual root fragments or bone spicules left when complete removal would require extensive surgery or needless surgical complications.
E. Possible bone fracture which may require wiring or surgical treatment.
F. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.
G. Injury to the nerve underlying the teeth resulting in itching, numbness, or burning of the lip, chin, gums, cheek, teeth, and/or tongue on the operated side; this may persist for several weeks, months, or, in remote instances, permanently.

(Initials) _____

I give my consent for the doctor to perform the treatment/procedure/surgery previously explained to me, or other procedures deemed necessary or advisable as necessary to complete the planned operation. If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgment or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever (s)he may deem advisable, including referral to another dentist or specialist. I also understand that the cost of this referral would be my responsibility.

(Initials) _____

4. FILLINGS:

I have been advised of the need for fillings, either silver or composite (plastic), to replace tooth structure lost to decay. I understand that with time fillings will need to be replaced due to wearing of material. In cases where very little tooth structure remains, or existing tooth structure fractures off, I may need to receive more extensive treatment (such as root canal therapy, post and build-up. and crowns), which would necessitate a separate charge.

I understand that the silver amalgam restoration is and acceptable procedure according to the American Dental Association guidelines and, as such, is a treatment used by this Dental Office. The advantages and disadvantages of alternates materials have been explained to me.

(Initials) _____

5. ENDODONTIC TREATMENT (ROOT CANAL THERAPY): The purpose and method of root canal therapy have been explained to me, as well as reasonable alternative treatments, and the consequences of non-treatment. I understand that following root canal therapy my tooth will be brittle and must be protected against fracture by placement of a crown (cap) over the tooth. I understand that treatment risks can include but are not limited to the following:

A. Post treatment discomfort lasting a few hours to several days for which medication will be prescribed if deemed necessary by the doctor.
B. Post treatment swelling of the gum area in the vicinity of the treated tooth or facial swelling, either of which may persist for several days or longer.
C. Infection.
D. Restricted jaw opening.
E. Breakage of root canal instruments during treatment, which may in the judgment of the doctor he left in the treated root canal or bone as part of the filling material. or y may require surgery for removal.
F. Perforation of the root canal with instruments, which may require additional surgical treatment or result in premature tooth loss or extraction.
G. Risk of temporary or permanent numbness in treatment area.

If an "open and medicate" or pulpotomy procedure is performed, I understand that this is not permanent treatment, and I need to pay for, and finish final root canal therapy. If root canal treatment is not finalized I expose myself to infection and/or tooth loss.

If failure of root canal therapy occurs, the treatment may have to be redone, root-end surgery may be required. or the tooth may have to be extracted.

(Initials) _____

6. CROWN AND BRIDGE (CAPS):

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth.

I understand that at times, during the preparation of a tooth for a crown, pulp exposure may occur, necessitating possible root canal therapy. I understand that like natural teeth, crowns and bridges need to be kept clean, with proper oral hygiene and periodic cleanings, otherwise decay may develop underneath and/or around the margins of the restoration, leading to further dental treatment.

(Initials) _____

7. DENTURES- COMPLETE OR PARTIAL:

The problems of wearing dentures have been explained to me including looseness, soreness, and possible breakage, and relining due to tissue change. Follow-up appointments are an integral part of maintenance and success of a prosthetic appliance. Persistent sore spots should be immediately examined by the doctor.

I further understand that surgical intervention (i.e. tori[bone] removal, bone recontouring, or implants) may be needed for dentures to be properly fitted. I also understand that due to bone loss or other complicating factors, I may never be able to wear dentures to my satisfaction.

(Initials) _____

8. PEDODONTICS (CHILD DENTISTRY):

I Understand that the following procedures are routinely used at this Dental Office as well as being accepted procedures in the dental profession.

A. POSITTVE REINFORCEMENT- Rewarding the child who portrays desirable behavior, by use of compliments, praise, a pat or hug, and/or token objects or toys.
B. VOICE CONTROL – The attention of a disruptive child is gained by changing the tone or increasing the volume of the doctor’s voice.
C. PHYSICAL RESTRAINT – Restraining the child's disruptive movements by holding down their hands, upper body, head, and/or legs by use of the dentist's or assistant's hand or arm, or by use of a special device (referred to as a "papoose board").
D. NITROUS OXIDE AND/OR ORAL SEDATION- Nitrous Oxide is a mild gas that is mixed with oxygen and is used to sedate a person. It is administered through a mask placed over the child's nose. Oral sedations are medications administered to children to help them relax. With their use the parent/or guardian must understand that the child should not eat or drink for a period of four hours prior to the sedation appointment. The parent/guardian must be available to escort the child home after the sedation procedure and observe their behavior throughout the day.

I understand that with the use of an injection, used to numb the tooth area for dental procedures, the possibility exists that the child may inadvertently bite their lip causing an injury to occur.

I understand the need to return to the office, for evaluation, if swelling and/or pain in my child does not go away after a sufficient period. I understand the need to return to the office within three months following nerve treatment of a "baby tooth" for evaluation, and the possibility of it then needing an extraction.

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HER/HIS CARE, REALIZING THAT ANY LACK OF SAME COULD RESULT NI LESS THAN OPTIMUM RESULTS.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITTUN THE ABOVE, INCLUDING THE OPPOSING SIDE OF THIS DOCUMENT, AND CONSENT TO THE OPERATION AND EXPLANATION REFERRED TO OR MADE. I HAVE BEEN ENCOURAGED TO ASK QUESTIONS AND HAVE HAD THEM ANSWERED TO MY SATISFACTION.

I UNDERSTAND THAT **ELLIOTT N. ABRAMS D.D.S** PROVIDES DENTAL CARE SERVICES WITHOUT DISCRIMINATION BASED ON RACE, RELIGION, COLOR, NATIONAL ORIGIN, SEX, SEXUALORIENTATION, PHYSICAL OR MENTAL DISABILITY, AGE OR MARITAL STATUS AND PROTECTS THE PRIVACY OF EACH OF IT'S PATIENTS.

Signature: ______________________________________ Relationship: __________ Date: __/__/____

Parent or legal representative

Doctor: ____ Witness: ____

ADA
American Dental Association®

HEALTH HISTORY FORM

E-mail: ______________________________ Today's Date: __/__/____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses is this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name ____________________ (Last, First, M)
Home Phone ( ) __________
Business/Cell Phone ( ) __________

Address ____________________ (Mailing Address)
City __________
State ________
Zip ________

Occupation ____________________
Height ________
Weight ______
DOB ___/___/_____
Sex M / F

SSN/Patient ID ______________
Emergency Contact ____________________
Relationship ______________
Phone ( ) __________

If you are completing this form for another person, what is your relationship to that person?
Your name: Relationship:

Do you have any of the following diseases or problems:
(check DK if you don't know the answer to the question)

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a three-week duration	☐	☐	☐
Cough that produced blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answered YES to any of the four items above, please stop and return this form at reception.

Dental Information

For the following questions, please mark X your responses to the following questions.

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, not, sweets or pressure?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with			

	Yes	No	DK
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐

previous dental treatments? .... ☐ ☐ ☐
Is your home water supplied fluoridated? .... ☐ ☐ ☐
Do you drink bottled or filtered water? .... ☐ ☐ ☐
If yes, how often? Circle one DAILY/WEEKLY/OCCASIONALLY
Are you currently experiencing dental pain
or discomfort? .... ☐ ☐ ☐
Do you have earaches or neck pains? .... ☐ ☐ ☐

Do you have any clicking, popping or discomfort
in the jaw? .... ☐ ☐ ☐

Do you brux or grind your teeth? .... ☐ ☐ ☐

Does food or floss catch between your teeth? .... ☐ ☐ ☐
Date of your last dental exam?
Date of last dental x-rays:
What was done at that time?

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information

Please mark X your response to indicate if you have or have not had any of the following disease or problem

Yes/No/DK

Are you now under the care of a physician? .... ☐ ☐ ☐
Physician Name: _________________________
Phone: (   ) _____ __________

Address/City/State/Zip:

Are you in good health? .... ☐ ☐ ☐
Has there been any change in your general
health within the past year? .... ☐ ☐ ☐
If yes, what condition is being treated?

Date of last physical exam: ___/___/_____

Have you had a serious illness, operation or
been hospitalized in the past 5 years? .... ☐ ☐ ☐
If yes, what was the illness or problem?

Are you taking or have you recently taken
prescription or over the counter medicine(s)? .... ☐ ☐ ☐
If so, please list all, including vitamins, natural
herbal preparations and/or diet supplements:

Do you wear contact lenses? .... ☐ ☐ ☐

Joint Replacement.
Have you had an orthopedic total joint
(hip, knee, elbow, finger) replacement? .... ☐ ☐ ☐
Date: ___/___/_____.
If yes, have you had any complications?

Are you taking or scheduled to begin taking

Yes/No/DK

either of the medications, alendronate
(Fosamax®) or Actonel®) for osteoporosis or
Paget's disease? .... ☐ ☐ ☐

Since 2001, were you treated or are you presently scheduled to
begin treatment with the intravenous bisphosphonates (Aredia®
or Zometa®) for bone pain, hypercalcemia or skeletal
complications results from Paget's disease, multiple myeloma
or metastatic cancer? .... ☐ ☐ ☐
Date Treatment began: ___/___/_____

Allergies - Are you allergic to or have you had a
reaction to:
Local anesthetics .... ☐ ☐ ☐
Aspirin .... ☐ ☐ ☐
Penicillin or other antibiotics .... ☐ ☐ ☐
Barbiturates, sedatives, or sleeping pills .... ☐ ☐ ☐
Sulfa drugs .... ☐ ☐ ☐
Codeine or other narcotics .... ☐ ☐ ☐
Metals .... ☐ ☐ ☐
Latex (rubber) .... ☐ ☐ ☐
Iodine .... ☐ ☐ ☐
Hay bever/seasonal .... ☐ ☐ ☐
Animals .... ☐ ☐ ☐
Food .... ☐ ☐ ☐
Other

Do you use controlled substance (drugs)? .... ☐ ☐ ☐
Do you use tobacco (smoking, snuff, chew, bidis)?.. ☐ ☐ ☐
If so, how interested are you in stopping?

VERY/SOMEWHAT/NOT INTERESTED

Do you drink alcoholic beverages? .... ☐ ☐ ☐
If yes, how much alcohol did you drink in the last 24 hours?

If yes, how much do you typically drink in a week?

WOMEN ONLY Are you:
Pregnant? .... ☐ ☐ ☐
Number of weeks: ______
Taking birth control pills or hormonal replacement? .... ☐ ☐ ☐
Nursing? .... ☐ ☐ ☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Yes/No/DK

Artificial (prosthetic) heart valve .... ☐ ☐ ☐

Previous infective endocarditis .... ☐ ☐ ☐
Damaged valves in transplanted heart .... ☐ ☐ ☐

Congenital heart disease (CHD)
- Unrepaired, cyanotic CHD .... ☐ ☐ ☐
- Repaired (completely) in last six months .... ☐ ☐ ☐
- Repaired CHD with residual defects .... ☐ ☐ ☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Yes/No/DK

Autoimmune disease ...... ☐ ☐ ☐

Rheumatoid arthritis .... ☐ ☐ ☐
Systemic lupus Erythematosus .... ☐ ☐ ☐
Asthma ....☐ ☐ ☐

Bronchitis .... ☐ ☐ ☐

Emphysema .... ☐ ☐ ☐

Sinus trouble .... ☐ ☐ ☐

Tuberculosis .... ☐ ☐ ☐

Yes/No/DK

Hepatitis, jaundice or liver disease .... ☐ ☐ ☐
Epilepsy .... ☐ ☐ ☐
Fainting spells or Seizures .... ☐ ☐ ☐
Neurological disorders ...... ☐ ☐ ☐

If yes, specify __________

Sleep disorder .... ☐ ☐ ☐

Mental health disorders .... ☐ ☐ ☐
Specify ____________

Yes/No/DK

Cardiovascular disease .... ☐ ☐ ☐
Angina .... ☐ ☐ ☐

Arteriosclerosis .... ☐ ☐ ☐
Congestive heart failure .... ☐ ☐ ☐
Damaged heart valves .... ☐ ☐ ☐
Heart attack .... ☐ ☐ ☐
Heart murmur .... ☐ ☐ ☐

Low blood pressure ... ☐ ☐ ☐

High blood pressure .. ☐ ☐ ☐
Other congenital heart .... ☐ ☐ ☐
Defects .... ☐ ☐ ☐

Yes/No/DK

Mitral valves prolapse .... ☐ ☐ ☐
Pacemaker .... ☐ ☐ ☐

Rheumatic fever ...... ☐ ☐ ☐
Rheumatic heart disease .... ☐ ☐ ☐
Abnormal bleeding ... ☐ ☐ ☐

Anemia .... ☐ ☐ ☐
Blood transfusion ...... ☐ ☐ ☐

If yes, date: ___/___/_____

Hemophilia .... ☐ ☐ ☐
AIDS or HIV infection ☐ ☐ ☐

Arthritis .... ☐ ☐ ☐

Yes/No/DK

Cancer/Chemotherapy/ Radiation Treatment .. ☐ ☐ ☐
Chest pain upon exertion ....☐ ☐ ☐
Chronic pain .... ☐ ☐ ☐
Diabetes type I or II ... ☐ ☐ ☐

Eating disorder .... ☐ ☐ ☐

Glaucoma .... ☐ ☐ ☐
Gastrointestinal disease .... ☐ ☐ ☐
G.E. Reflux/persistent heartburn .... ☐ ☐ ☐
Ulcers .. .. ☐ ☐ ☐
Thyroid problems .... ☐ ☐ ☐

Stroke ....☐ ☐ ☐

Yes/No/DK

Recurrent infections ☐ ☐ ☐

Type of infection ________

Kidney problems ...... ☐ ☐ ☐

Night sweats .... ☐ ☐ ☐

Osteoporosis .... ☐ ☐ ☐
Persistent swollen glands in neck .... ☐ ☐ ☐
Severe headaches/ migraines .... ☐ ☐ ☐

Severe or rapid weight loss .... ☐ ☐ ☐
Excessive urination .. ☐ ☐ ☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? .... ☐ ☐ ☐
Name of the physician or dentist making recommendation:

Do you have any disease, condition, or problem not listed above that you think I, as the dentist, should know about? .... ☐ ☐ ☐
Please explain:

Note: Both Doctor and patient are encouraged to discuss all relevant patient health issues prior to treatment

I certify that I have read and understood the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to by satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date: ___/___/_____

FOR COMPLETION BY DENTIST

Comments: