El Paseo Dental Care

INFORMED CONSENT FOR TREATMENT

I understand that by initialing and signing below, I am requesting and authorizing the procedure(s) to be performed and I have read and understand the possible risks and complications of the procedure(s).

I understand that I am having the following dental procedures completed today:

X-rays & Photographs: (Taking of intra-oral and extra-oral radiographs). Benefits of treatment: taking x-rays enables us to view dental cavities, abnormalities, development and eruption of teeth. X-rays and photos are also necessary for proper diagnosis and evaluation purposes. Alternatives of treatment: **none;** limited visual examination. Common risks: radiation exposure to soft and hard tissues. Consequences of not performing the treatment: missed diagnosis. **Initial: _____**

Prophylaxis: Today I will be receiving a professional prophylaxis (cleaning) by a Registered Dental Hygienist. Dental cleanings are essential for maintaining health in your mouth. Overtime, bacteria, food debris, and calcified (hardened) material can accumulate on your teeth that your tooth brush cannot remove. Some people get this accumulation much quicker and in greater amounts than others. It may be recommended that you receive professional cleaning every 3, 4, 6 or 12 months depending on your level of need. **Risks:** Teeth may become sensitive to air, hot or cold stimuli, TMJ (Jaw Joint) may become tender due to prolonged mouth opening, & tenderness may be present in the gums for a short time after a cleaning. **Initial:** _____

Treatment Plan Estimates: I understand that fees quoted to me for treatment are only an estimate and subject to modification depending upon unforeseen or un-diagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have that I am responsible for payment of any and all dental treatment rendered. There has been no guarantee or assurance made by anyone in regard to the dental treatment I am authorizing**. Initials: _____**

NOTICE: By signing this agreement, you are agreeing to have any issue of fees, treatment, or alleged malpractice decided by a binding neutral arbitration, and you are giving up your right to a jury or court trial.

Print Name: _____

Signature: _____

Today's Date: _____

Witness:_____

EL PASEO DENTAL CARE
Patient Information

Patient Name: _____ **Date of Birth:**_____

Preferred: _____ **Male:** _____ **Female:** _____ **Single:** ____ **Married:** ____ **Child:** ____

Parent/Guardian if patient is a child: _____ **Patient SS#** _____

Home Address: _____**City:**_____ **State:**_____ **Zip:**_____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Employer:** _____

Email Address: _____ **Best time to call:** _____

Whom may we thank for referring you to our office: _____

Medical History Update

GENERAL HEALTH: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

☐Y ☐ N Under a physician's care now?

☐Y ☐N Any hospitalization in the past 5 years? .....

☐Y ☐ N Any serious illnesses/surgeries? .....

☐Y ☐ N Use tobacco in any form? If Yes, Type: .....

☐Y ☐ N Is pre-medication required before dental visits due to heart condition or artificial joint?

FEMALE PATIENTS: ☐Y ☐N Currently nursing? ☐Y ☐N Currently pregnant? Due Date: .....

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐ Y ☐ N
If yes, please describe:

.....

Is there anything important about your medical condition we have not asked? ☐ Y ☐ N If yes, please describe:

.....

Dental Insurance Information

Name of Primary Insurance: _____Group #:_____

Subscribers Name: _____Subscribers DOB:_____

Subscribers SS# or Ins ID#_____ Employer: _____

ALLERGIES/ALLERGIC REACTIONS

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

- ☐ ASPIRIN
- ☐ ANESTHETIC – LOCAL
- ☐ BARBITURATES
- ☐ CODEINE
- ☐ DAIRY
- ☐ LATEX
- ☐ LACTOSE INTOLERANCE
- ☐ METAL SENSITIVITY
- ☐ NITROUS OXIDE SEDATION
- ☐ SLEEPING PILLS
- ☐ SULFA DRUGS
- ☐ PENICILLIN/OTHER ANTIBIOTICS
- ☐ NONE

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

- ☐ ACID REFLUX
- ☐ ADHD
- ☐ AIDS/HIV
- ☐ ANEMIA
- ☐ ANOREXIA
- ☐ ANXIETY
- ☐ ARTIFICIAL HEART VALVE
- ☐ ARTIFICIAL JOINTS
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ AUTISM/ASPERGER'S
- ☐ BLEEDING DISORDER
- ☐ BULIMIA
- ☐ CANCER/MALIGNANCY
- ☐ CEREBRAL PALSY
- ☐ CHEMICAL DEPENDENCY
- ☐ CHICKEN POX
- ☐ CONVULSIONS
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ DIZZINESS/FAINTING
- ☐ EPILEPSY/SEIZURES
- ☐ FREQUENT EAR INFECTIONS
- ☐ FREQUENT HEADACHES
- ☐ HEARING PROBLEMS
- ☐ HEART ATTACK
- ☐ HEART DISEASE
- ☐ HEART MURMUR
- ☐ HEPATITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ KIDNEY DISEASE
- ☐ LIVER PROBLEMS
- ☐ MITRAL VALVE PROLAPSE
- ☐ MONONUCLEOSIS
- ☐ PACEMAKER
- ☐ OTHER – PLEASE LIST: _____
- ☐ PSYCHIATRIC TREATMENT
- ☐ RADIATION/CHEMO
- ☐ RESPIRATORY DISEASE
- ☐ RHEUMATIC FEVER
- ☐ SINUS PROBLEMS
- ☐ STROKE
- ☐ THYROID CONDITION
- ☐ TUBERCULOSIS
- ☐ ULCERS
- ☐ VENEREAL DISEASE

☐ OTHER – PLEASE LIST _____

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

- ☐ ANTIBIOTICS/SULFA DRUGS
- ☐ BLOOD THINNERS
- ☐ INSULIN
- ☐ RECREATIONAL DRUGS
- ☐ OTC DRUGS/ MEDICATIONS (PLEASE LIST BELOW)
- ☐ ANTIHISTAMINES/ALLERGY
- ☐ CANCER/CHEMO MEDICATIONS
- ☐ NITROGLYCERIN
- ☐ THYROID MEDICATIONS
- ☐ OTHER (PLEASE LIST BELOW)
- ☐ DAILY ASPIRIN
- ☐ CORTISONE/STEROIDS
- ☐ ORAL CONTRACEPTIVES
- ☐ TRANQUILIZERS
- ☐ BLOOD PRESSURE MEDICATIONS
- ☐ HEART MEDICATION/DIGITALIS
- ☐ OSTEOPOROSIS MEDICATIONS
- ☐ OTHER DIABETIC MEDICATIONS

DRUG NAME	DOSAGE	REASON PRESCRIBED

PATIENT CONSENT

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

Signature: _____ DATE: _____

RELATIONSHIP TO PATIENT: ☐ADULT PATIENT ☐PARENT ☐GUARDIAN ☐OTHER