GENERAL DENTISTRY INFORMED CONSENT

1. WORK TO BE DONE

I understand that I am having the following work done: Exam, X-rays, Prophylaxis (Cleaning), and Other _______________

X (Initials _____)

2. DRUGS AND MEDICATION

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock.

X (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. For example, root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

X (Initials _____)

4. FILLINGS

I understand that care must be exercised in chewing on fillings, especially during the first 24 hours to avoid breakage. I understand that a more extensive filling that originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling.

(Initials _____)

5. REMOVAL OF TEETH

Alternatives to removal of teeth 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 other 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 (paresthesis) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

(Initials _____)

6. CROWNS, BRIDGES AND CAPS

I understand that no guarantee has been given that the proposed treatment will be to my complete satisfaction. 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 the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation.

(Initials _____)

7. 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 root canal filling material may extend through the tooth, which does not necessarily affect the success of the treatment. I understand the endodontic files and reamers are very fine instruments and stresses vented in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it.

(Initials _____)

8. 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. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse affect on my periodontal condition.

(Initials _____)

9. DENTURES

I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficult in eating are common problems. Immediate denture (placements of denture immediately after extractions) may be painful. Immediate denture may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted denture(s). Is a remake is required due to my delays of more than 30 days, there will be additional charges.

(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 no other Dentist is responsible for my dental treatment.

I hereby authorize any of the doctors of dental auxiliaries to proceed with an perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosed circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

Signature of Patient or Guardian **X** ____ Date _______________

PATIENT MEDICAL HISTORY

Patient's Name: ______________________________ Birthdate: ______________________

CHECK ONE	YES	NO
1. Are you under medical treatment now?	( )	( )
2. Have you ever been hospitalized for any surgical operation or serious illness?	( )	( )
3. Are you taking any medication(s), including non-prescription medicine?	( )	( )
If yes, what medication(s) are you taking? ______________________________		
4. Do you use tobacco?	( )	( )
5. Do you use alcohol, cocaine or other drugs?	( )	( )
6. Are you wearing contact lenses?	( )	( )
7. Are you taking Fosamax (for Osteoporosis)?	( )	( )
Are you taking Fen Phen (diet pills)?	( )	( )

8. Physician______________________________

Office Phone ______________________________

Date of Last Exam ______________________

	YES	NO
9. Does your medical doctor recommend prophylactic antibiotic before any dental procedures?	( )	( )

10. Are you allergic to or have you any reactions to the following?	YES	NO
Local Anesthetics (e.g. Novocain)	( )	( )
Penicillin or other Antibiotics	( )	( )
Sulfa Drugs	( )	( )
Barbiturates	( )	( )
Sedatives	( )	( )
Iodine	( )	( )
Aspirin	( )	( )
Latex	( )	( )
Other ________________	( )	( )

11. Women Only:	YES	NO
a) Are you pregnant?	( )	( )
b) Are you nursing?	( )	( )
c) Are you taking birth control pills?	( )	( )

12. Do you have or have you had any of the following?

	YES	NO		YES	NO		YES	NO
High Blood Pressure	( )	( )	Heart Disease	( )	( )	Chest Pain	( )	( )
Low Blood Pressure	( )	( )	Heart Murmur	( )	( )	Stroke	( )	( )
Recent Weight Loss	( )	( )	Heart Attack	( )	( )	Psychiatric Care	( )	( )
AIDS or HIV Infection	( )	( )	Cardiac Pacemaker	( )	( )	Cancer	( )	( )
Joint Replacement or Implant	( )	( )	Frequently Tired	( )	( )	Anemia	( )	( )
Sexually Transmitted Disease	( )	( )	Hay Fever / Allergies	( )	( )	Angina	( )	( )
Stomach Troubles / Ulcers	( )	( )	Respiratory Problems	( )	( )	Glaucoma	( )	( )
Fainting / Seizures	( )	( )	Hepatitis / Jaundice	( )	( )	Asthma	( )	( )
Epilepsy / Convulsions	( )	( )	Tuberculosis	( )	( )	Emphysema	( )	( )
Radiation Therapy	( )	( )	Easily Winded	( )	( )	Arthritis	( )	( )
Rheumatic Fever	( )	( )	Swollen Ankles	( )	( )	Leukemia	( )	( )
Liver Disease	( )	( )	Kidney Disease	( )	( )	Osteoporosis	( )	( )
Thyroid Problem	( )	( )	Diabetes	( )	( )	Other	( )	( )
Back Problems	( )	( )				______________________		

PATIENT DENTAL HISTORY

Name of Previous Dentist: ______________________________ Date of Last Dental Exam: ______________________

	YES	NO
1. Do your gums bleed while brushing and flossing?	( )	( )
2. Are your teeth sensitive to hot /cold liquids/foods?	( )	( )
3. Are your teeth sensitive to sweet/sour liquids/foods?	( )	( )
4. Do you feel pain to any of your teeth?	( )	( )
5. Do you have any sores or lumps in or near you mouth?	( )	( )
6. Have you had any head, neck or jaw injuries?	( )	( )
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking?	( )	( )
b) Pain (joint, ear, side of face)?	( )	( )
c) Difficulty in opening or closing?	( )	( )
d) Difficulty in chewing?	( )	( )

	YES	NO
8. Do you have frequent headaches?	( )	( )
9. Do you clench or grind your teeth?	( )	( )
10. Do you bite your lips/cheeks frequently?	( )	( )
11. Have you ever had any difficult extractions in the past?	( )	( )
12. Have you had any orthodontic work?	( )	( )
13. Have you every had any prolonged bleeding following extractions?	( )	( )
14. Have you ever had instruction on the correct method of brushing your teeth?	( )	( )
15. Have you had instructions on the care of your gums?	( )	( )

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I also understand that it is my responsibility to inform the office of any changes in my medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or myself during the period of dental care to third party payers and or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf of my dependents.

____

Signature of patient or parent if minor Date

ACKNOWLEDGEMENT OF RECEIPT

I have received the following information packet:

Office Practice Information

Dental Board Fact Sheet Initial ____________

CONSENT OF USE/DISCLOSURE OF HEALTH INFORMATION

To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Patient/Guardian Signature____

Windsmile©

FAMILY DENTAL PRACTICE

Lourdes R. Gaerlan, D.M.D., Inc.

141 Sunset Ave. Ste. I and J – Suisun City, CA 94585 – (707) 421-8190 – Fax (707) 421-9145

4757 Mangels Blvd. – Fairfield, CA 94534 - (707) 864-1010 – Fax (707) 864-8051

PATIENT INFORMATION Today's Date ____________________

Name ____ ( ) Married ( ) Single ( ) Minor / ( ) Male ( ) Female

SS# ____________________________ Driver License # ______________________ Birthdate ________________________

Address ____ City ____________________ State _________ Zip ___________

Home Phone (_____)_________________ Cell Phone (_____)__________________ Work Phone (_____)__________________

Do you prefer to receive calls at: ( ) Home ( ) Cell ( ) Work ( ) No Preference

When are the best times to reach you? ____

Email Address ____

Patient Employer/School ____ Occupation _______________________________

Employer/School Address ____________________________________ City________________ State _______ Zip __________

Spouse or Parent's Name _____________________________________ Phone (_____)___________________________________

Person to contact in case of emergency ____Phone (_____)________________

Other family members seen by us: ____

Whom may we thank you for referring you to us? ____

RESPONSIBLE PARTY

Person Responsible for account ( ) Patient ( ) Guardian ( ) Spouse ( ) Father ( ) Mother

Name of person responsible for account _____________________________________ Phone (_____)______________________

INSURANCE INFORMATION

Name of insured _______________________________________ Relationship to patient _______________________________

Birthdate ______________ SS# ________________ Phone (_____)_______________ Email __________________________

Name of Employer _______________________________ Address ____

Insurance Company _______________________________ Group # ___________________ Phone (_____)________________

Do you have additional insurance? ( ) No ( ) Yes If yes, please complete the following:

Name of insured _______________________________________ Relationship to patient _______________________________

Birthdate ______________ SS# ________________ Phone (_____)_______________ Email __________________________

Name of Employer _______________________________ Address ____

Insurance Company _______________________________ Group # ___________________ Phone (_____)________________

AUTHORIZATION

I, the undersigned patient/guardian authorize payment directly to Lourdes R. Gaerlan, D.M.D., Inc./Windsmile Family Dental Practice of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I authorize the use of my signature on all insurance submission. I hereby authorize Lourdes R. Gaerlan, D.M.D., Inc./Windsmile Family Dental Practice to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

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Patient/Guardian Signature Date