Patient Identification:

Name: _____
DOB: _____
Pt ID #: _____

Consent for Anesthesia Services

I, _____, acknowledge that my doctor has explained to me that I will have a restorative or surgical dental procedure. My doctor has explained the risks of the procedure, advised me of alternative treatments, and told me about the expected outcome and what could happen if my condition remains untreated. I also understand that anesthesia services are needed or requested so that my doctor can perform the procedure(s).

It has been explained to me that all forms of anesthesia involve some risks and no guarantees or promises can be made concerning the results of my procedure or treatment. Although rare, unexpected severe complications with anesthesia can occur and include the remote possibility of infection, bleeding, drug reactions, blood clots, paralysis, stroke, brain damage, heart attack, or death. I understand that these risks apply to all for s of anesthesia and that additional or specific risks have been identified below as they may apply to a specific type of anesthesia. I understand that the type(s) of anesthesia service checked below will be used for my procedure and that the anesthetic technique to be used is determined by many factors including my physical condition, the type of procedure my doctor is to do, my doctor's preference, and my own preference. It has been explained to me that sometimes and anesthesia technique which involves the use of local anesthetics, with or without sedation, may not succeed completely and therefore another technique may have to be used including general anesthesia.

General Anesthesia

- Expected Result:
  Total unconscious state, possible placement of a tube into the windpipe
- Technique:
  Drug injected into the bloodstream, breathed into the lungs, or administered by other routes.
- Risks:
  Mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, aspiration, pneumonia.

Monitored Anesthesia Care (with sedation)

- Expected Result:
  Reduced anxiety and pain, partial or total amnesia
- Technique:
  Drug injection into the blood stream, breathed into the lungs, or administered by other routes producing a semi-conscious state.
- Risks:
  An unconscious state, depressed breathing, injury to blood vessels

Monitored Anesthesia Care (without sedation)

- Expected Result:
  Measurement of vital signs, availability of anesthesia provider for further intervention
- Technique:
  None
- Risks:
  Increased awareness, anxiety and/or discomfort

I hereby consent to the anesthesia service checked above and authorize that it be administered by ------ or his/her associates, all of whom are credentialed to provide anesthesia services at this healthcare facility. I also consent to an alternative type of anesthesia, if necessary, as deemed appropriate by them. I expressly desire the following considerations be observed (or write "none")

_____

I certify and acknowledge that I have read this form or had it read to me; that I understand the risks, alternatives and expected results of the anesthesia service; and that I had ample time to ask questions and to consider my decision.

_____ _____
Patient's Signature. Date/ time

_____ _____
Substitute's signature Relationship to patient

_____
Witness

Consent For Oral Surgery Using IV Sedation or General Anesthesia

1. _____I authorize Dr. _____ and staff to treat my condition. The procedure necessary has been explained to me, and I understand it to be:

   _____

   _____

2. _____I have been informed of possible alternate treatment options and understand that no treatment at all is also a choice.

3. _____The doctor has explained to me that there are risks in **ANY** procedure. We do not expect these to occur, but there is that possibility. In this instance such risks include, but are not limited to, the following:

   A. _____Opening of the sinus requiring additional surgery
   B. _____Injury to the nerve in the jaw resulting in numbness or tingling of the chin, lip, cheek, gums, and/or tongue; this may persist for days, weeks, or in remote instances permanently.
   C. _____Postoperative discomfort and swelling
   D. _____Heavy bleeding that may be prolonged
   E. _____Injury to adjacent teeth and restorations
   F. _____Postoperative infection requiring additional treatment
   G. _____Stretching of the corners of the mouth
   H. _____Restricted mouth opening for several days
   I. _____Decision to leave a small piece of root in the jaw when it's removal would require extensive surgery
   J. _____Breakage of the jaw
   K. _____Soreness in injection site or along the vein may develop
   L. _____Cardiac or respiratory arrest or even death
   M. _____Other: _____

4. _____It has been explained to me that, during the course of the procedure(s) unforeseen conditions may necessitate an extension of the original procedures or different procedure(s) than those described above. I authorize and request the doctor perform such procedures as are necessary in the exercise of professional judgment.

5. _____I consent to the administration of anesthesia, including local, intravenous and/or general anesthesia with the exception of: _____ to which I said I was allergic.

6. _____Medications and anesthetics may cause drowsiness and lack of coordination, which can be increased by use of alcohol or other drugs; thus, I have been advised and agree not to operate any vehicle, automobile, or hazardous devices, or work, while taking such medications; or until fully recovered from the effects of same. I agree not to drive myself home after my discharge from surgery if I am put to sleep.

7. _____It has been explained to me, I understand, that a perfect result is not guaranteed or warranted.

8. _____I agree a d understand I am not to have and/or have not had anything to eat or drink for eight (8) hours before my surgery if I am going to be put to sleep.

9. _____I agree to cooperate with the recommendations of the doctor while under his/her care, realizing that lack of same could result in a less than optimum result.

10. _____I have read and fully understand this consent for surgery. **PLEASE ASK THE DOCTOR IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT FORM BEFORE SIGNING IT.**

_____	_____
Patient's signature Date	Parent or legal guardian (if under 18) Date
_____	_____
Witness (professional staff member) Date	Doctor Date

Welcome To Our Office . . .

A B C

Patient Information

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security #_____

Employer_____ Occupation_____

E-Mail Address_____ Work Phone_____ Cell Phone_____

If patient is a minor, give parent's or guardian's name _____

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

Responsible Party Information

Name _____ _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address_____Home Phone _____ Work Phone_____

E-Mail Address_____ _____ Cell Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____Birthdate _____ Relationship to Patient _____

Employer _____Occupation_____No. Years Employed____
Last First Middle

Spouse's Name _____Relationship to Patient_____

Employer _____Occupation_____No. Years Employed____

Social Security # _____Birthdate_____Work Phone_____

*I understand that where appropriate, credit bureau reports may be obtained.

Insurance Information

Insured's Name_____ Insured's Soc. Sec. #_____

Insurance Company _____ Group No._____Local No._____

Insurance Co. Address _____

Do you have dual coverage? Yes ☐No ☐ If yes:

Insured's Name_____Insured's Soc. Sec. #_____

Insurance Co. Address _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Relationship (sister, father, etc.) _____

Complete Address _____

Phone _____

*Signature_____

Medical History

Physician_____ Address & Phone Number_____

Are you in good health?_____ If no, explain_____

Do you have an existing illness?_____ If yes, explain_____

Do you bleed excessively when cut?_____ Do you smoke?_____ if yes, how much_____

Are you taking any medications?_____ If yes, please list_____

_____

Do you now have, or have you had, any of the following?_____

	YES	NO		YES	NO
1. Heart Disease	_____	_____	14. Hepatitis	_____	_____
2. High Blood Pressure	_____	_____	15. Asthma	_____	_____
3. Blood Disease	_____	_____	16. Tuberculosis	_____	_____
4. Rheumatic Fever	_____	_____	17. Anemia	_____	_____
5. Heart Murmur	_____	_____	18. AIDS	_____	_____
6. Diabetes	_____	_____	19. Other	_____	_____
7. Stroke	_____	_____	20. Allergy to (a) Penicillin	_____	_____
8. Epilepsy	_____	_____	21. (b) Other Antibiotics_____	_____	_____
9. Arthritis	_____	_____	22. (c) Local Anesthetics_____	_____	_____
10. Tumor History	_____	_____	23. (d) Other_____	_____	_____
11. Radiation Disease	_____	_____	24. Are you pregnant? (for women)	_____	_____
12. Liver Disease	_____	_____	25. Have you had any type of joint		
13. Kidney Disease	_____	_____	replacements?	_____	_____

Dental History

Previous Dentist_____ Date of last visit_____ Yes No

Last full mouth x-rays_____ Last complete dental exam_____

What is your immediate dental concern?_____

Have you had Orthodontics?_____ ☐ ☐

1. Are you troubled with dryness in your mouth?_____ ☐ ☐
2. Do you have chronic headaches?_____ ☐ ☐
3. Have you ever had periodontal treatment or gum surgery?_____ ☐ ☐

   If yes, when?_____ By whom?_____

4. Have you ever been informed you have gum problems?_____ ☐ ☐

   If yes, when?_____ By whom?_____

5. Do your gums bleed when you brush your teeth?_____ ☐ ☐
6. Are you aware of any growths or swelling in your mouth?_____ ☐ ☐

   If yes, where and how long have they existed?_____ ☐ ☐

7. Are you aware of your jaw clicking, popping, or making grating-like noises?_____ ☐ ☐

   If yes, when?_____ ☐ ☐

8. Do your jaw muscles feel, tired, stiff, or painful?_____ ☐ ☐
9. Do you grind your teeth during the day? Do you grind your teeth during the night?_____ ☐ ☐
10. Are you frustrated by needing constant dental repair because of active dental disease?_____ ☐ ☐
11. Are you anxious about dental treatment?_____ ☐ ☐
12. Are you concerned about the finances required to return your mouth to a state of excellent dental heath?_____ ☐ ☐
13. Do you use dental floss? if yes, how often?_____ ☐ ☐
14. What did you like the <u>BEST</u> about your previous dentist?_____ ☐ ☐
15. What did you like the <u>LEAST</u>?_____ ☐ ☐
16. If you could change one thing about the appearance of your smile, what would it be?_____ ☐ ☐

_____

Peach Tree Dental

Patient Name: _____

Surgery Date: _____Time: _____

At: _____ (location)

You will be having IV sedation or general anesthesia.

REMEMBER.....

A. Do not eat or drink anything eight (8) hours prior to your surgery time. Nothing by mouth (no gum, candy, tobacco, smoking).

B. If you take heart, high blood pressure, seizures, or psychotropic medications they should be taken the morning of surgery with a sip of water. Do not take diabetic medications, vitamins, arthritis medication, or herbal supplements.

C. Clean your teeth and mouth well prior to surgery

D. Have someone bring you to the facility and be sure that your driver is able to stay in the facility while you have the procedure done. Do not operate a vehicle or heavy machinery after the procedure.

E. You will need to have someone who can stay with you the first twenty-four (24) hours after your procedure.

F. One hour before your appointment, take four (4) 200mg Ibuprophen with a very small amount of water. If you have been instructed not to take ibuprophen by a physician due to allergy or medical complication, DO NOT take it for this appointment.

G. Additional medical instructions:
_____
_____
_____
_____

_____ _____

Signature Date

Patient Name (print): _____

CONSENT FOR ORAL AND MAXILLOFACIAL SURGERY AND ANESTHESIA

I hereby authorize Dr. _____ and staff to perform the following procedure:

_____

And to administer the anesthesia I have chosen, which is:

- ❑ Local
- ❑ Local with oral pre-medication
- ❑ Local with nitrous oxide/oxygen analgesia

Other treatment options:_____

_____

- I understand that certain complications may occur as a result of my surgery, which include (but are not limited to): swelling, bruising, stiffness of jaw muscles and jaw joints (TMJ) which may be long lasting, or unexpected drug reactions or allergies.

- With tooth extraction, I understand that there may be unexpected damage to adjacent teeth or fillings, sharp ridges, or bone splinters that may require later surgery to smooth or remove, dry socket which will require additional care, or small fragments of tooth root which may be left in place to avoid damage to vital structures such as nerves or sinus.

- Lower tooth roots may be very close to the nerve and surgery may result in pain or a numb feeling of the chin, lip, cheek, gums, teeth, or tongue lasting for weeks, months, or may rarely be permanent. On upper teeth whose roots are close to the sinus, a sinus infection may develop, a root tip may enter the sinus and/or an opening from the mouth to the sinus may occur which could require later medication or surgery.

- I understand that no guarantee can be promised and I give my free and voluntary consent for treatment. I realize that my doctor may discover conditions requiring different surgery from that which was planned, and I give my permission for those additional procedures that are advisable in the exercise of professional judgment.

My signature below signifies that all questions have been answered to my satisfaction regarding the consent and I fully understand the risks involved of the proposed surgery and local anesthesia. I certify that I speak, read, and write English.

Patient's (or Legal Guardian's) Signature Date

Doctor's Signature Date

Witness' Signature Date

Medical Health Questionnaire For IV Sedation

Date _____
Name _____
DOB _____
Phone _____

1. Height _____ Weight _____
2. Are you now, or have you recently been under the care of a physician? Yes No
   If yes, why?
   _____
   _____
3. Have you recently had any medical tests? Yes No
   If yes, list
   _____
   _____
4. Have you been hospitalized for any illness or injury? Yes No
   If yes, list
   _____
   _____
5. What surgeries have you had?
   _____
   _____
6. Have you or your parents ever had a problem with anesthesia? Yes No
7. Do you have any allergies? Yes No
   If yes, list
   _____
   _____
8. Do you smoke? Yes No
9. Do you drink alcohol? Yes No
10. Please list all medications or herbal supplements you take:
    _____
    _____
    _____
11. Is there a possibility you could be pregnant? Yes No
12. Do you wish to speak with your doctor or anesthetist privately? Yes No

13. Please check the following that apply:

High Blood Pressure	_____
Heart Disease	_____
Chest Pain	_____
Shortness Of Breath	_____
Irregular Heart rate Or Rhythm	_____
Peripheral Vascular Disease	_____
History Of Heart Attack	_____
If yes, When?	_____
Heart Surgery Or Stint	_____
EKG, Stress Test, Heart Cath	_____
Breathing Problems	_____
Asthma, COPD, Emphysema	_____
Recent Bronchitis, Pneumonia, Flu	_____
Acid Reflux	_____
Ulcer, Hernia	_____
Frequet Nausea, Vomiting	_____
Gastric By-Pass Surgery	_____
Kidney Or Prostate Problems	_____
Diabetes	_____
Cancer	_____
TB, Hepatitis, HP Blood Transfusion	_____
Neurologic Problems	_____
Lupus, Fibromyalgia	_____
Sickle Cell Or Any Anemia	_____
History Of Stroke, TIA, Seizure	_____
Neck Or Back Problem	_____
Arthritis	_____