*Welcome *

*We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we’ll be glad to help you. We look forward to working with you in maintaining your dental health.*

**PATIENT INFORMATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Soc. Sec. #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAST NAME FIRST NAME INITIAL

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: ⧠ M. ⧠ F. Age: \_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Single ⧠ Married ⧠Widowed ⧠ Separated ⧠ Divorced

Patient Employed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notify in case of emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY INSURANCE**

**Dental Insurance: ⧠ Yes or ⧠ No**

Policy Holders Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Soc. Sec. #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acknowledgment**

**I am aware of Dr. Jaffar Elahi’s Notice of Privacy Practices. A copy is available at my request**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Health History**

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Why are you now seeking dental treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please answer each question. Check yes or no. If in doubt, leave blank***. YES / NO

1. Are you in good health now? ............................................................................................................. () ()
2. Are you now under the care of a physician? ……………………………………………………….. () ()

If so, what is the condition being treated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever been hospitalized or had a serious illness? ……………………………………………………. () ()

If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously? ………………………………………………………………………………………………………………………… () ()
2. (Woman) Are you pregnant? If so, give due date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ () ()
3. Do you use tobacco in any form? If yes, how much \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ () ()
4. Do you use alcoholic beverages (more than 2 drinks per day)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ () ()
5. Do you have or have you ever had any of the following?

**GENERAL YES/NO HEART/BLOOD VESSELS YES/NO**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Tire easily, weakness………………………………………. | () | () | Rheumatic fever ………………………………… | () | () |  |
| Marked weight change ………………………………….... | () | () | Heart murmur …………………………………… | () | () |  |
| Night sweats ………………………………………………….. | () | () | Chest pain/ discomfort ……………………… | () | () |  |
| Persistent fever ………………………………………………. | () | () | Heart attack/trouble …………………………. | () | () |  |
| **SKIN** |  |  | Shortness of breath …………………………… | () | () |  |
| Eruptions (rash) hives……………………………………… | () | () | High blood pressure ………………………….. | () | () |  |
| Change in skin color ………………………………………… |  |  | Congenital heart disease ……………………. | () | () |  |
| **EYES** |  |  | Mitral valve prolapse…………………………. | () | () |  |
| Visual change …………………………………………………. | () | () | Artificial heart valve…………………………… | () | () |  |
| Glaucoma ……………………………………………………….. | () | () | Pacemaker ………………………………………… | () | () |  |
| **EARS** |  |  | Heart Surgery …………………………………….. | () | () |  |
| Loss of hearing………………………………………………… | () | () | Other …………………………………………………. | () | () |  |
| Ringing in ears………………………………………………… | () | () | **BONE/MUSCLES** |  |  |  |
| **NOSE** |  |  | Arthritis/rheumatism ………………………... | () | () |  |
| Frequent nosebleeds ………………………………………. | () | () | Artificial joints/limbs ………………………... | () | () |  |
| Sinus problems ……………………………………………….. | () | () | **DIGESTIVE SYSTEM** |  |  |  |
| **THROAT** |  |  | Hepatitis …………………………………………… | () | () |  |
| Soreness/hoarseness ……………………………………..... | () | () | Jaundice ……………………………………………. | () | () |  |
| **NERVOUS SYSTEM** |  |  | Ulcers ……………………………………………….. | () | () |  |
| Stroke ……………………………………………………………… | () | () | Change in appetite …………………………….. | () | () |  |
| Headaches ……………………………………………………….. | () | () | Black, bloody or pale stools ……………….. | () | () |  |
| Convulsions/epilepsy ………………………………………. | () | () | **URINARY** |  |  |  |
| Numbness/tingling …………………………………………. | () | () | Kidney disease …………………………………... | () | () |  |
| Dizziness/fainting …………………………………………… | () | () | Increase in frequency |  |  |  |
| Psychiatric treatment ……………………………………… | () | () | of urination (night) …………………… | () | () |  |
| **RESPIRATORY** |  |  | Burning on urination ………………………… | () | () |  |
| Tuberculosis……………………………………………………. | () | () | Urethral discharge …………………………….. | () | () |  |
| Emphysema ……………………………………………………. | () | () | Bloody urine ……………………………………… | () | () |  |
| Asthma/hay fever …………………………………………… | () | () | Venereal disease ………………………………... | () | () |  |
| Persistent cough ……………………………………………... | () | () | **BLOOD** |  |  |  |
| Sputum production (phlegm) ………………………….. | () | () | Bruise easily ……………………………………… | () | () |  |
| Cough up bloody sputum ………………………………… | () | () | Anemia ……………………………………………… | () | () |  |
| Difficulty breathing while lying down………………. | () | () | Blood transfusion ……………………………… | () | () |  |
| **ENDOCRINE** |  |  | **OTHER** |  |  |  |
| Diabetes …………………………………………………………. | () | () | Radiation therapy ……………………………… | () | () |  |
| Family history of diabetes ……………………………….. | () | () | Chemotherapy …………………………………… | () | () |  |
| Thyroid condition/goiter …………………………………. | () | () | Tumors or growths ……………………………. | () | () |  |
| Other ………………………………………………………………. | () | () | Cancer ………………………………………………. | () | () |  |
|  | | | HIV + ………………………………………………... | () | () |  |
|  | | | AIDS ……………………………………………………….. | () | () |  |

1. Are you ALLERGIC or have you ever experienced any reaction to the following?

YES / NO YES / NO

Local anesthetics (e.g. novocaine) ……………………… () () Aspirin or codeine ……………………… () ()

Barbiturates/sedatives/sleeping pills ………………… () () Sulfa drugs ………………………………… () ()

Penicillin/other antibiotics ………………………………… () () Other allergies ……………………………. () ()

1. Are you taking any of the following? YES / NO YES / NO

Antibiotics/sulfa drugs ……………………………………… () () Tranquilizers …………………………….. () ()

Blood thinners ………………………………………………….. () () Insulin/other diabetes drugs ……. () ()

Blood pressure medication ……………………………….. () () Recreational drugs ………… () ()

Thyroid medicine ……………………………………………. () () Digitalis/other heart

Medications ………………………... () ()

Cortisone/steroids ……………………………………………. () () Nitroglycerin ………………………… () ()

Antihistamines/allergy drugs/cold remedies …… () () Aspirin ……………………………………… () ()

List names of medications you take and dosage below:

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Physicians Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Other Specialist Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Have you ever had any serious trouble associated with previous dental treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Does dental treatment make you nervous? No \_\_\_\_\_\_\_\_ Slightly \_\_\_\_\_\_\_\_ Moderately \_\_\_\_\_\_\_\_ Extremely \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Date of last dental visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Have you ever been treated for periodontal disease (gum disease, pyorrhea, and trench mouth)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If so, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have or have you ever had any of the following?

**MOUTH YES / NO TEETH YES / NO**

Bleeding, sore, gums …………………………… () () Loose teeth …………………………………… () ()

Unpleasant taste/bad breath ……………… () () Sensitive to hot ……………………………... () ()

Burning tongue/lips …………………………… () () Sensitive to cold ……………………………. () ()

Frequent blisters, lips/mouth …………….. () () Sensitive to sweets ………………………... () ()

Swelling/lumps in mouth …………………… () () Sensitive to biting ………………………….. () ()

Ortho treatments (braces) ………………….. () () Food impaction ……………………………… () ()

Biting cheeks/lips ………………………………. () () Clenching/grinding ……………………… () ()

Clicking/popping jaw …………………………. () () Shifting of teeth …………………………… () ()

Difficulty opening or closing jaw …………. () () Change in bite ……………………………… () ()

**ORAL HYGIENE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you use the following? **YES / NO**

Brush ……………………………………………………………. () () How often do you brush \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental floss …………………………………………………… () () Brush is: Soft () Medium () Hard ()

Fluoride rinse ……………………………………………….. () ()

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To the best of my knowledge, all of the preceding answers are true and correct.

If I ever have any change in my health or change in my medication. I will inform the dentist at the next appointment.

Signature of patient,

Parent, or Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DR. JAFFAR ELAHI

GENERL DENTISTRY INFORMED CONSENT

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Account Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. WORK TO BE DONE

I understand that I am having the following work done. () fillings, () bridges, () crowns, () x-rays, () root canal, () extraction’s, () dentures () other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Initials \_\_\_\_\_\_\_\_\_

1. DRUGS AND MEDICATIONS

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

Initials \_\_\_\_\_\_\_\_\_\_

1. CHANGES IN TREATMENT

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. I give my permission to the dentist to make any/all changes and additions as necessary to the success of my treatment.

Initials \_\_\_\_\_\_\_\_\_\_\_

1. REMOVAL OF TEETH

Alternatives t removal of my 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 others necessary for reasons as explained to me. I understand that removing teeth does not always remove all the infection, if present and it may be necessary to have further treatment. I understand that risks involved in having teeth removed, including: pain, swelling, spread of infection, dry socket, fractured jaw, and the loss of feeling in my teeth, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time. I understand that may need further treatment by a specialist if complications arise during or following treatment that cost of which is my responsibility.

Initials \_\_\_\_\_\_\_\_\_\_

1. TEMPORMANDIBULAR JOINT (TMJ)

I have been informed that my bite is not correct and failure to have my bite properly rehabilitated before any dental procedure might be the cause of possible pain or damage to the teeth, jaw joint, or muscles of the head and neck.

Initials \_\_\_\_\_\_\_\_\_\_

1. 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 it 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 that 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 the tooth preparation date. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or cap. I understand that there will be additional charges for remakes due to my delaying permanent cementation. Initials \_\_\_\_\_\_\_\_\_\_\_\_

1. 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 effect on my periodontal condition.

Initials \_\_\_\_\_\_\_\_\_\_\_\_

1. DENTURES

I understand that wearing dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures, (placement of dentures immediately after extractions), may be painful. Immediate dentures may require considerable adjusting and 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 within 30 days. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days, there will be an additional charge to me.

Initials \_\_\_\_\_\_\_\_\_\_\_\_

I understand that dentistry is not an exact science and that reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the success of dental treatment, which I have requested and authorized. I understand that no other dentist is responsible for my dental treatment. I hereby authorize any dentist or dental auxiliaries of Dr. Jaffar Elahi’s office to proceed with and perform the dental treatments and restorations as explained to me. I understand that is only an estimate subject to modification due to unforeseen or diagnosable circumstances that may arise during treatment. I understand that regardless of any dental insurance I may have, I am responsible for payment of dental fees. If the patient or responsible party defaults in payment, Dr. Jaffar Elahi may exercise all rights and remedies allowed by law, including the right to hold the patient liable for damages, which are, the unpaid balance, collection fees, and possible attorney fees.

Signature of patient or responsible party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_