PATIENT INFORMATION/ Informed Consent

BEARDEN FAMILY DENTISTRY

Patient's Name (Last)	First	Middle	Date Of Birth

Mailing Address	City	State	Zip

Phone #	Sex	Marital Status	Social Security #

Spouse's Name (Parent If Minor)	Phone #	Date of Birth	Social Security #
Do You Have Dental Insurance?	Name of Insurance	Group #	Id #
Name of Policy Holder	DOB of Policy Holder	Relationship	Who May We Thank For Referring You?

You have the right to accept or reject treatment recommendations from your Dentist. This form is intended to provide you with an overview of potential risks and complications. It is very important that you provide your dentist with an accurate medical history before undergoing dental treatment. During treatment, the following care will be provided to you:

1) **Examination & X rays – X rays are required to complete your examination, diagnosis, and treatment plan. A periodic examination will be provided by the dentist at all routine cleanings to evaluate your teeth for decay, gum disease, oral cancer, and overall health.**
2) **Dental Prophylaxis (Cleaning) A routine cleaning involves the removal of plaque and calculus above the gum line and will not address gum infections below the gum line called periodontal disease. Some bleeding may occur after a cleaning, however, should it persist and if it's severe in nature please call the office.**
3) **Scaling and Root Planning (SRP/Deep Cleaning) This treatment involves removing the bacterial substance known as plaque, which is the principal cause of periodontal disease and calculus (tarter). A topical and or local anesthetic may be administered depending on the sensitivity of the area being treated.**

I understand that because cleanings involve contact with bacteria and infected tissue in the mouth, you may experience post op symptoms which would be treated with the appropriate medication. I also understand that after any dental treatments I may experience some of the following.

- **Discomfort/Swelling that may persist for several days.**
- **Stretching of the corners of the mouth with resultant cracking and bruising.**
- **Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth, and/or tongue on the side where anesthetic was used: this may persist for several days, weeks, months, or in some instances permanently.**
- **Swelling, bruising, and bleeding of the gum tissue.**
- **Shrinkage of gum tissue.**
- **Sensitivity/Loosening of teeth.**
- **Exposure of margins of previous crowns or caps.**

No Show/Cancelation Policy

We ask for a 24-hour cancellation notice on all standard hygiene visits. We require 48-hour cancellation notice for hygiene visits where multiple family members are scheduled together or visits that are scheduled with the doctor for dental treatment. We understand that circumstances arise that are out of your control so please call to discuss. We also request your understanding of the fact that we have other patients on a waiting list wanting to be seen.

- 1st no show/short notice cancellation -warning
- 2nd no show charge of $83.00
- 3rd no show a deposit will need to be made before scheduling any future appointments.
- If a family fails to cancel within the appropriate time frame, we will not schedule you as a family on your next visit.

My signature certifies that I have read and understand, if you have any questions, please feel free to ask.

Signature: _____ Date: _____

Dental/Medical History

Patient's Name: _____

Previous Dentist: _____ Date of Last Visit/Cleaning: _____
What is the reason for today's visit? _____
Are you experiencing any discomfort or pain? If yes, please explain? _____
Are there any other concerns you would like to discuss today? _____
How often do you brush? _____ How often do you floss? _____
What would you like to improve? _____
How would you rate your smile 1-10? _____Type of toothbrush do you use? □Hard □Medium □Soft
Have you ever had an allergic reaction to Local Anesthetics? If yes, please explain? □ Yes □ No _____
_____
Do you use tobacco? □ Yes □ No If yes for how long._____
Do you Vape? □ Yes □ No If yes for how long. _____
Do you use illicit drugs? □ Yes □ No If yes what kind _____

Please check all that apply:

□ Bad Breath
□ Bleeding Gums
□ Blisters on lips/inside mouth
□ Broken filling/Crown off
□ Fingernail biting
□ Grinding teeth
□ Loose teeth
□ Pain around Ear
□ Periodontal Treatment
□ Sensitivity to cold
□ Sensitivity to heat
□ Sensitivity to sweets
□ Sensitivity when biting
□ Frequent Headaches
□ Jaw, head or neck injuries or pain
□ Jaw clicking
□ Tooth Pain

Medical History

Please check all that apply:

□ Aids
□ Anemia
□ Alcohol/Drug Abuse
□ Artificial Joint Replacement
□ Asthma
□ Blood Disease
□ Back Problems
□ Cancer
□ Cold Sores/Fever Blisters
□ COPD/SOB
□ Diabetic
□ Type □ 1 □ 2
□ Epilepsy/Seizures
□ Excessive Bleeding
□ Glaucoma
□ Head Injury
□ Headaches
□ Heart Murmur
□ Heart Valve Replacement
□ Heart Attack
□ Heart Disease
□ Heart Surgeries
□ Hepatitis Type □A□B□C
□ Herpes
□ High Blood Pressure
□ HPV
□ Jaw Pain
□ Kidney Disease
□ Low Blood Pressure
□ Liver Disease
□ Mental Health Illness
□ Nursing
□ Pregnant
□ Radiation/Chemo
□ Respiratory Problems
□ Rheumatic Fever
□ Scarlett Fever
□ Sinus Problems
□ Stroke
□ Swelling of Ankles/Feet
□ Swollen Neck Glands
□ Thyroid Problems
□ Tonsillitis
□ Tuberculosis
□ Tumor or Growth on Head
□ Ulcers
□ Other

Have you ever used Osteoporosis medicine known as Bisphosphonates? □ Yes □ No
Do you have Sleep Apnea? □ Yes □ No If yes do you wear a CPAP? □ Yes □ No
Please list any surgeries. _____
Please list regular medications. _____
_____
Do you have any allergies to food or medications? _____
Do you require antibiotics (as a pre-med) before dental treatment? □ yes □ no □ unsure

To the best of my knowledge all the information is correct, it's my responsibility to inform Bearden Family Dentistry if there are any changes to my medications or medical history.

Signature: _____ Date: _____