

ANY METAL INSIDE YOUR BODY FROM SURGERIES? (Pins, screws, plates, tubes, mesh, etc.): YES _____ NO _____
PHARMACY: _____

PATIENT'S DENTAL CONSENT

East Central Oklahoma Family Health Center, Inc.
109 South Main, Wetumka, OK 74883; 217 South 5th, Henryetta, OK 74437

Date: _____ Time: _____

1. I, _____, (the _____ of _____), hereby consent voluntarily to dental care including diagnostic procedures, examination and dental treatment including but not limited to routine work and administration of medication prescribed by the dentist.
2. I consent for treatment by a hygienist or dentist designee as necessary in the dentist judgment.
3. I consent to performance of oral surgery, oral or IV sedation, use of nitrous oxide, etc.
4. I consent to photographs or X-rays necessary for diagnosis, and for educational purposes.
5. I understand only appropriately trained personnel will do these procedures.
6. I understand that this consent form will be valid and remain in effect as long as I use the clinic, or until revoked in writing.
7. I have been notified of ECOFHC's policy not to honor any DNR. A copy will be provided to other facilities as needed.

RELEASE OF INFORMATION:

1. I authorize the clinic to release medical information to third party insurance carriers for the purpose of filing insurance claims related to my medical care.
2. I also authorize payment directly to East Central Oklahoma Family Health Center, Inc. but not to exceed the customary chart for those services.
3. I agree to pay the balance not covered by insurance in the manner agreed upon at the time of my income review.
4. Payment history may also be released.
5. I give consent for information regarding my immunizations to be released to other Health Care Providers, Schools, Day Care, and/or Department of Human Services.
6. The information authorized for release may include records which indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as Hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS); and may include information about drugs, alcohol and sickle cell anemia [63 O.S. 1-502.2 (B)].

This form has been fully explained to me and I understand its contents.

ACKNOWLEDGEMENT OF PRIVACY PRACTICE: A complete description of how your medical information will be used and disclosed by this facility is in our **NOTICE OF PRIVACY PRACTICES**. A copy is included in your welcome packet and is made available to you.

COMMENTS: _____

Signature of Patient or Person Authorized to Consent for Patient

Signature of Person who Explained the Contents of this Consent

If patient is a minor or is unable to consent, complete the following:

- A. Patient is a minor _____ years of age.
Name of Father _____ Mother _____
- B. Patient is unable to consent because: _____

EAST CENTRAL OKLAHOMA FAMILY HEALTH CENTER, INC.
EXTRACTION CONSENT

The recommendation that one or more of your teeth be extracted is based upon your symptoms, examination of your mouth, or your choice. A surgical procedure may be required to gain access to those teeth to be extracted. In many cases an incision will be made in the gum tissue and bone may be removed to gain access. We want you to be aware of the commonly known risks and side effects of this procedure.

Due to proximity, teeth adjacent to those to be extracted, may be chipped or damaged during extraction.

Nerves which supply sensation to your mouth, chin, lips, tongue and gum tissue may run near the area of the extraction. After the extraction you may experience some alteration of normal nerve sensation (itching, burning or tingling, for example) for a short or indefinite period of time. In some rare instances you may experience a total lack of sensation for a period of time which could be indefinite.

For teeth in the upper arch, there is a risk that following the extraction, a hole or pathway may be present between the sinus and the oral cavity. This is because the roots of some of the upper teeth end just below the floor of the sinus and sometimes actually go through the sinus floor.

Occasionally, the decision is made to leave a small piece of root in the jaw after an extraction in cases when its removal would require extensive surgery and increase the risk of complications.

Following the procedure, the muscles of your jaw may be stiff and sore. It may also be difficult to open wide for several days. This is usually a temporary condition in which moist heat and analgesics will provide pain relief. Occasionally, the jaw joint (TMJ) may be injured due to extended opening required for the procedure. In addition, bone fractures can occur.

You may experience pain, swelling or bleeding for a time after the extraction. If any of these problems occur, they should only last for a few days. Should any of these problems be more severe or last longer than anticipated, call our office immediately.

You may also experience a painful but harmless condition commonly referred to as a dry socket. This occurs when the protective blood clot in the socket where the tooth was removed, is dislodged. This exposes and irritates the delicate nerve endings in the socket. This is usually caused by failing to closely follow the post-operative instructions given. Although the condition is temporary and not harmful, it is painful. It can be treated by a in-house procedure. Medicine is placed in the socket which will soothe and protect it while alleviating the pain.

If you have any further questions, be sure to consult your dental professional. By signing below, you acknowledge that you have read this document, understand the information presented, had all of your questions answered satisfactorily, understand that you may see a specialist and are choosing to see the treating dentist and consent to the indicated treatment.

Patient Name (please print)

Procedure

Signature of patient, legal guardian or authorized representative

Date

Witness to signature

Date

**EAST CENTRAL OKLAHOMA FAMILY HEALTH CENTER, INC
DENTAL HEALTH HISTORY**

The benefits of a happy, health smile are immeasurable. Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. If you need assistance with this form, we will be happy to help you. The better we communicate, the better we can care for you.

All About You

Name: _____
I prefer to be called: _____
Birthdate: _____
Home Phone #: _____
Cell Phone #: _____

Date: _____
Chart Number: _____
Male: _____ Female: _____
Work Phone #: _____
Ext. #: _____

Other family Members seen in our dental clinic: _____
Previous/Past Dentist: _____
Date of last dental visit: _____

In the event of an emergency, who should be contact: _____
Name: _____
Relation: _____
Home #: _____
Work #: _____

Dental History:

Why have you come to the dentist today?

Are you experiencing dental pain? Yes _____ No _____
Explain: _____

Date of last dental visit: _____

Have you ever had a serious/difficult problem associated with any previous dental work?
No _____ Yes _____ Explain: _____

Do you experience jaw joint discomfort (TMJ, TMD)? _____

Your current dental health is: Good: _____ Fair: _____ Poor: _____

Do you like to smile? _____

Do your gums bleed? _____

How many times a day do you brush? _____

What type of bristles do you use? Hard: _____ Medium: _____ Soft: _____

Do you floss? Yes: _____ No: _____ How Often: _____

What type of water do you drink? Bottled: _____ City (name) _____ Well _____

Medical History

Do you have a personal physician? Yes _____ No _____ Name: _____

Phone #: _____ Date of last visit: _____

Your current health is: Good _____ Fair _____ Poor _____

Is your physician treating you for a specific condition? Yes _____ No _____

Please explain, if yes: _____

List all current medications and dosages: _____

Females only:

Are you pregnant? Yes _____ No _____ If yes, week # _____

Are you nursing? Yes _____ No _____

Are you taking birth control pills? Yes _____ No _____

Please check any condition you currently have or have had in the past.

Cardiovascular:

Heart failure _____	Heart disease or attack _____	Angina pectoris (chest Pain) _____
High blood pressure _____	Low blood pressure _____	Heart Murmur _____
Mitral valve prolapsed _____	Rheumatic fever _____	Congenital heart defect _____
Artificial heart valve _____	Arrythmias _____	Heart pacemaker/defibrillator _____
Heart transplant _____	Heart surgery _____	Prior Phen-fen use _____
Stroke _____	Aneurysm _____	Other heart problems _____

Hematologic:

Blood transfusion _____	Anemia _____	Hemophilia _____
Leukemia _____	Sickle Cell disease _____	Tendency to bleed longer _____

Neural and sensory:

Eye pain _____	Vision problems _____	Glaucoma or cataracts _____
Earaches _____	Ringing in ears _____	Hearing loss _____
Severe headaches _____	Fainting/dizziness _____	Epilepsy _____
Nervousness _____	Psychiatric treatment _____	Development delay _____

Gastrointestinal

Stomach ulcers _____	Gastritis _____	Colitis _____
Persistent diarrhea _____	Liver disease _____	Yellow jaundice _____
Cirrhosis _____	Hepatitis _____	Hep A _____ Hep B _____ Hep C _____

Respiratory

Hay fever _____	Sinusitis _____	Seasonal allergies _____
Asthma _____	Chronic cough _____	Emphysema _____

Form 402 Dental Health History

Tuberculosis (TB) _____ Breathing difficulty (COPD) _____ Supplemental oxygen _____

Endocrine

Diabetes _____ Insulin-dependent (IDDM) _____ Non-insulin dependent (NIDDM) _____
 Thyroid Disease _____ Hyper-thyroidism _____ Hypo thyroidism _____

Urinary/Sexually Transmitted Diseases

Urinate frequently _____ Kidney problems _____ Bladder problems _____
 Sexually transmitted disease (STD: syphilis, gonorrhea, genital herpes) _____
 HIV-Positive _____ AIDS (or exposed) _____

Dermal/Skeletal

Latex allergy _____ Abnormal mole _____ Osteoporosis _____
 Sore Muscles _____ Stiff joints _____ Arthritis _____
 Artificial joint _____ Fever blisters _____ Mouth ulcers (canker sores) _____

Other Conditions

Frequent sore throats _____ Enlarged lymph node _____ Tumor or cancer _____
 Radiation treatment _____ Chemotherapy _____ Surgical removal of tumor _____
 Use of tobacco _____ Smokeless tobacco _____ Cigarettes/Cigars _____
 # of packs per day _____ # of years tobacco use _____ Alcohol use _____
 Drug addiction _____ Steroid therapy _____ Other conditions _____

Drug Allergies

Aspirin _____ Codeine _____ Penicillin _____ Erythromycin _____
 Sulfa _____ Tetracycline _____ Latex _____ Dental anesthetic _____
 Other _____ No known drug allergies _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patient Signature

Date

Reviewed By

Date