Patient Name: _____ _____

Address_____ _____Marital Status M S

City _____State_____ Zip_____Date of Birth_____ SS #_____

Email_____ CELL PHONE_____

Emergency Contact_____ Contact's Phone_____

Physician's Name_____ Physician's Phone _____

Employer's Name_____ Employer's Phone_____

Dental Insurance Company (Primary)_____(Secondary)_____

How did you hear about us?_____

1. Have you seen your physician in the last year? Why _____

2. List all current medications and purpose (including birth control) _____

_____

3. What is the reason for your visit? _____

4. How long has it been since your last cleaning?_____

5. Please circle any of the following that you now have or have ever had:
Rheumatic fever Asthma Any Blood Disorder Diabetes Seizures Arthritis Kidney Disease
Tuberculosis Venereal Disease Heart Attack/Disease Heart Murmur Cancer Immune System Disorder
High Blood Pressure Bleed Easily AIDS/HIV Liver Disease/Hepatitis Pregnancy------ Due Date _____
Please explain any of the above conditions that you have or any other conditions _____
_____

6. Have you ever had an unusual reaction or are you allergic to any of the following?	YES	NO
Penicillin, Aspirin, Acetaminophen, Ibuprofen, Codeine, Sulfa Drugs, Barbiturates, Latex		
OTHER_____		
7. Are you or could you possibly be pregnant	YES	NO
8. Do you require antibiotic pre-medication for a heart condition, artificial valve or joint?	YES	NO
9. Have you ever had any severe reaction to dental treatment or local anesthetics?	YES	NO
10. Do you have a history of substance abuse?	YES	NO
11. Do you smoke/chew tobacco?	YES	NO
12. Do you consume alcohol?	YES	NO
13. Have you ever taken a Bisphosphonate (example Boniva, Actonel, Fosomax)?	YES	NO
14. Are you interested in straightening your teeth?	YES	NO
15. Is there anything you would like to change about your smile?	YES	NO

I Hereby certify that the answers to the foregoing questions are accurate to the best of my ability. Since a change in my medical condition or in medications I take can affect dental treatment, I understand the importance of and agree to take the responsibility to notify the dentist of any changes at any subsequent appointment.

Signature_____ Date_____

CONSENT TO PROCEED

I authorize Dr. Gregory J Randall and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name:_____

Signature:_____ **Date:**_____

(Patient, legal guardian or authorized agent of patient)

Witness:_____ **Date:**_____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

I give Quarry Bend Dental my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies and for health care operations like quality reviews. I have been informed that I may review Quarry Bend Dental's notice of privacy practices (for a more complete description of uses and disclosures) before signing this consent. I understand that Quarry Bend Dental has the right to change their privacy practices and that I may obtain any revised notice. I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Quarry Bend Dental is not required to agree to the request. If the practice agrees to my requested restriction they must follow the restrictions. I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

Patient's Signature_____ **Date** _____