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; 104 E. Shurden Industrial Blvd. , 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 charge 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: _____

Revised 03/10

Form 404

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: _____ **Date:** _____
I prefer to be called: _____ **Chart Number:** _____
Birthdate: _____ **Male:** _____ **Female:** _____
Home Phone #: _____ **Work Phone #:** _ _____
Cell 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** _____

Form 402 Dental Health History

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 Murmer**	_____
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***