Lowell Tooth Docs
59 Lowes Way
Suite 202
Lowell MA 01851
(978)454-8400
www.lowelltoothdocs.com
info@lowelltoothdocs.com

Informed Consent for General Dental Procedures

Patient Name:* ____________ * ____________ ____ ____________
Last First MI Preferred Name

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions have been answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read the items listed below and sign at the bottom of the form.

Treatment to be provided:

I understand that during the course of my treatment that the following care may be provided:
Examinations * Diagnostic Services * Preventative Services * Restorations * Local Anesthesia * Periodontal Services * Other

Drugs and Medications:

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). It is my responsibility to report any of these occurrences and immediately and report to the nearest emergency room for further evaluation.

Changes in Treatment Plan:

I understand that during the treatment it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

No Implied Guarantee:

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot properly guarantee results. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results. I acknowledge that no guarantee or

MEDICATIONS: Are you taking or have you recently taken any prescription or over-the-counter medicine(s)? If so, please list all, including vitamins, natural or herbal preparations, and/or dietary supplements:

MEDICATION PURPOSE

*

Physician (Name, Location, Phone)

Date of last physical exam:

Are you taking or scheduled to begin taking any medications for osteoporosis? (ex: Fosamax, Boniva, Reclast)

*

Do you currently use or have you ever used tobacco (smoking, snuff, chew)? If yes, please describe type, how often, and amount.

*

Have you had an orthopedic total joint (hip, knee, elbow, finger, other) replacement or a Heart Valve Replacement? If yes, has your doctor recommended that you premed prior to dental appointments? If yes, what antibiotic do you take?

*

WOMEN ONLY - Check if any of the following apply:

- [ ] Pregnant
- [ ] Nursing
- [ ] Taking Birth Control Pills
- [ ] Taking Hormone Replacement

Response Date:

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Confidential Medical History

Patient Name:* [ ] Last * [ ] First [ ] MI [ ] Preferred Name

Medical Conditions- Please select/verify to indicate if you have had any of the following:

- [ ] *EPI Sensitivity
- [ ] *Pre-Med - Amox
- [ ] *Pre-Med - Other
- [ ] Acid Reflux
- [ ] ADD/ADHD
- [ ] Allergy - Other
- [ ] Allergy-Aspirin
- [ ] Allergy-Clindamycin
- [ ] Allergy-Codeine
- [ ] Allergy-Erythro
- [ ] Allergy-Hay Fever
- [ ] Allergy-LATEX
- [ ] Allergy-Penicillin
- [ ] Allergy-Sulfa
- [ ] Anemia
- [ ] Anxiety
- [ ] Arthritis/Rheumatism
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Autism
- [ ] Back Problems
- [ ] Blood Thinners
- [ ] Cancer/Tumors
- [ ] Chemo/Radiation
- [ ] Circulatory Problems
- [ ] Cortisone Treatments
- [ ] Daily Aspirin Use
- [ ] Diabetes
- [ ] Drug Addiction Hx
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Head/Facial Trauma
- [ ] Heart Problems
- [ ] Heart Valve Replaced
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV/AIDS
- [ ] Jaw Pain
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Pacemaker
- [ ] Psychiatric Care
- [ ] Respiratory Problems
- [ ] Stroke
- [ ] Swollen Ankles/Feet
- [ ] Thyroid Disease
- [ ] Tuberculosis
- [ ] z OTHER NOT LISTED

Clarify any of the above medical conditions or list any additional medical conditions or ALLERGIES. Has there been any change in your general health within the past year?

*

Have you had any problems with previous dental work such as prolonged numbness, sensitivity to epinephrine, or difficulty getting numb?

*

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Patient Information:

Chart#: ____________
FOR OFFICE USE ONLY

Patient Name: ____________ ____________ ____ ____________
Last | First | MI | Preferred Name

Title: ________ Mr/Ms/Mrs/etc   **Gender:** ◯ Male ◯ Female   **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ________   **Prev. Visit:** ________   **Email Address:** ____________

Phone: ________ ________ ________ ____   **Best time to call:** ________
Home | Mobile | Work | Ext

Address: ____________ ____________
Address 1 | Address 2

____________ ______ _____-____
City | State | Zip Code

Patient's Occupation and Employer or School Social Security #

____

____

How did you hear about us?

____

____

Primary Dental Insurance

Name of Insured:

____

____

Patient's Relationship to Insured:

◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name/Group #/Employer Name

____

____

Date of Birth of Subscriber/Subscriber ID #/Social Security #

____

____

____

Response Date: ___/___/______