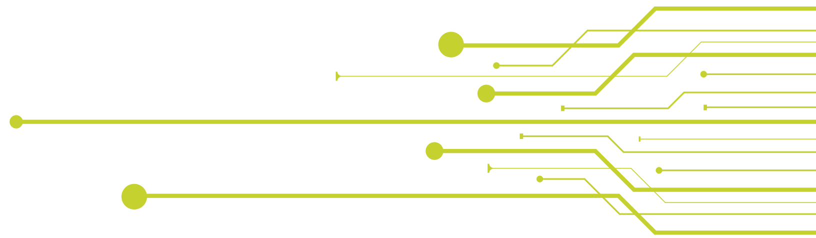
HI-TECH
DENTISTRY



1. Patient Information

Name: ______________________ Preferred Name: ______________ Gender: Male or Female

Birthdate: ______________ Social Security #: ______________________ ☐ Single ☐ Married ☐ Divorced

Home Address: ______________________ City: ____________ State: __________ Zip: __________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Email Address: ______________________ Preferred Contact Method: ______________

Employer: ______________________ Occupation: ______________________

Spouse's/Parent's Name: ______________ Spouse's/Parent's Work Number: ______________

Emergency Contact: ______________ Relationship: ____________ Phone: ______________

How did you hear about our office? ______________________

2. Medical History

Are you currently under a physician's care? Yes No If so, why: ______________

Please list all current medications: ______________________

Are you pregnant? Yes No If yes, when are you due? ______________

Do you or have you had any of the following? *Please circle*

Alzheimer's Disease	Artificial Heart Valves	Emphysema	Hemophilia	Mitral Valve Prolapse
Anaphylaxis	Asthma	Epilepsy	Hepatitis	Psychiatric Problems
Anemia	Cancer/Tumor	Fainting spells	Diabetes	Shortness of Breath
Angina	Cold/fever sores	Infectious Disease	Sinus Trouble	Tuberculosis
Anxiety attack	Heart Disease/Defect	Heart Attack	Kidney Problem	Heart Murmur
Artificial Joints	Hi/Lo Blood Pressure	Radiation	Stroke	Other ______

Do you have a **latex allergy**? Yes No

Allergic to: **Penicillin, Codeine, Local Injected Anesthetics**? Other Allergies: ______________

Tobacco use? Yes No

Have you ever had to pre-medicated with antibiotic for dental appt? Yes No

Surgeries? What type and when: ______________________

Do you have a history of Chemical/Alcohol dependency? Yes No

Any other health concerns? ______________________

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Date of LAST Dental Exam & Xrays & Cleaning? ______________________

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Authorization and Release

1. I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I certify that I &/ my dependent have insurance coverage above and assign directly to Hi-Tech Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurances submissions. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.
2. I hereby authorize and direct the dentist of Hi-Tech Dentistry &/ dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedures, including the use of any necessary or advisable local anesthesia, X-rays, or diagnostic aids.
   A- Preventive hygiene treatment (prophylaxis) & the application of topical fluoride
   B- Application of plastic sealants to the grooves of the teeth
   C- Treatment of diseased or injured teeth with dental restorations (fillings & crowns)
   D- Replacement of missing teeth with dental prostheses (bridges, partial dentures, full dentures)
   E- Removal (extractions) of 1 or more teeth
   F- Treatment of diseased or injured oral tissues (hard or soft)
   G- Treatment of crooked teeth &/ oral development or growth abnormalities
3. I understand that there are risks involved in this treatment & hereby acknowledge that these risks will be explained to me that I will have an opportunity to ask questions regarding the treatment & the risks and that I fully understand the same.
4. I agree to the use of local anesthesia, nitrous oxide/oxygen analgesia, sedative drugs, physical restraints or voice control depending on the judgment of the doctors. Nitrous oxide/oxygen may occasionally produce nausea & vomiting. I am also aware that the nosepiece leaves an indentation or ring around the nose, which disappears shortly after the procedure. I understand and have been informed of the above risks & complications.
5. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize & request the performance of any additional procedures that are deemed necessary or desirable to oral health & well-being in the professional judgment of the dentist.
6. There are possible risk & complications associated with the administration of local anesthesia, sedation & drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling & numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip & cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.
7. I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment record for the purpose of teaching, research, and scientific publications.
8. I will be advised that the success of the dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instructions of the dentists. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.
9. I hereby state that I have read & understand this consent, and that all questions about the procedures will be answered in a satisfactory manner. I understand that I have the right to be provided answers to questions which may arise during & after the course of my treatment.
10. I further understand that this consent will remain in effect until such time that I choose to terminate it
11. I have reviewed a copy of the office's Notice of Privacy Practice.

Patient's Signature: ______________________ **Date:** ______________

Responsible Party Signature: ______________ **Relationship:** __________ **Date:** __________

Doctor's Signature: ______________________ **Date:** ______________