Mr.
Mrs.
Miss

REGISTRATION DATE

DATE OF BIRTH S M W D

HOME ADDRESS HOME PHONE

CITY STATE ZIP CODE

E-MAIL CELL PHONE SS#/SIN

EMPLOYER ADDRESS

OCCUPATION BUS.

PREVIOUS ADDRESS TEL.

PERSON RESPONSIBLE FOR ACCOUNT CITY STATE

ADDRESS

REFERRED BY PHYSICIAN

DENTAL INSURANCE PROGRAM LOCAL NO.

PURPOSE OF CALL

PREFERRED DAY FOR APPTS. TIME AM PM

REMARKS

Item 053-0022/1063 Patterson Office Supplies 800-637-1140

MEDICAL HISTORY

1. Are you in good health? _____
2. Are you under a physician's care now? _____ If so, please give reason for treatment.
   _____
3. Are you taking any kind of medication at this time? _____
4. Have you ever taken Fen-Phen/Redux? _____
5. Please circle any illnesses you have ever had:

allergies	tuberculosis	anemia	kidney or liver	other
rheumatic fever	diabetes	heart trouble	asthma	
infectious hepatitis	epilepsy	glaucoma	HIV infection	

6. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? _____
7. Have you ever had trouble with prolonged bleeding after surgery? _____
8. Have you ever had any unusual reaction to an anesthetic or drug (like penicillin)?
   _____
9. Is there any other information that should be known
   about your health? _____
   about previous dental visits? _____
   _____

Signature

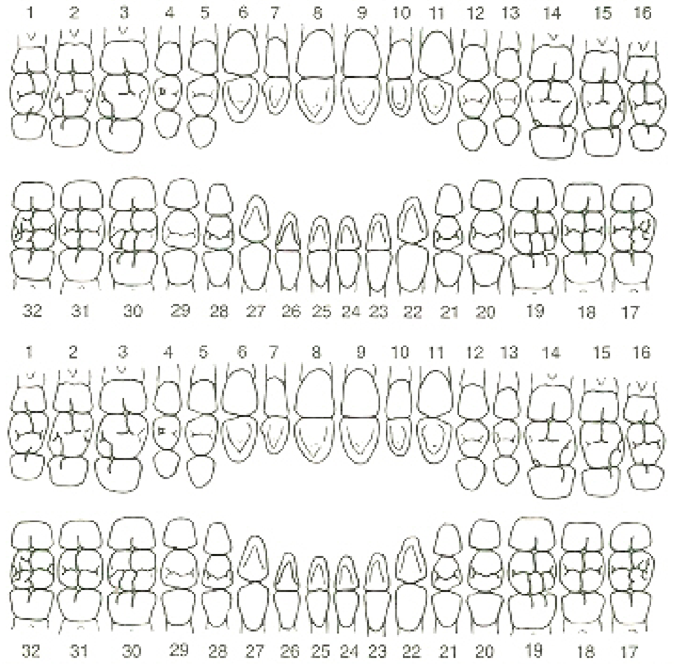
NAME AGE SEX S M W D

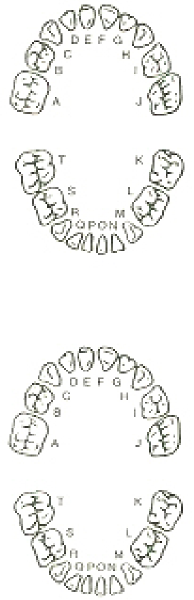
ADDRESS PHONE DATE

E-MAIL CELL PHONE

SPONSOR ADDRESS

OCCUPATION REF. BY ACKN





ORAL FINDINGS

HYGIENE 1 2 3 4

DEPOSITS 1 2 3 4

PERIODONT 1 2 3 4

OCCLUSION 1 2 3 4

RADIOGRAPHS

COMPLAINT

HISTORY

REMARKS

Item 056-2140/5424 Patterson Office Supplies 800-637-1140

NAME ADDRESS

DATE	TOOTH	SERVICE RENDERED	TIME	CHARGE	PAID	BALANCE

Aspen Hill Implant & Family
4110 Aspen Hill Rd Ste 301
Rockville MD 20853

Informed Consent Form for General Dental Procedures

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 are answered. By consenting to 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.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so s/he can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on oral birth control medication you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to the following:

1. Pain, swelling, and discomfort after treatment.
2. Infection in need of medication, follow-up procedure or other treatment.
3. Temporary, or on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums, and tongue along with possible loss of taste.
4. Damage to adjacent teeth, restorations or gums.
5. Possible deterioration of your condition which may result in tooth loss.
6. The need for replacement of restorations, implants or other appliances in the future.
7. An altered bite in need of adjustment.
8. Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist.
9. Root tip, bone fragment or a piece of dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop.
10. Jaw fracture.
11. If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment.
12. Allergic reaction to anesthetic or medication
13. Need for follow-up treatment, including surgery.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

Patient Signature	Date	Witness	Date
Print Patient Name		Parent/Legal Guardian	Date