Thai K. La, D.D.S.
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Orlando, FL 32808
Office: (407) 299-9099
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Authorization and Informed Consent to Dental Treatment

I request and authorize Dr. Thai La, DDS and/or such other persons as he/she may appoint, to perform or assist in the performance of the dental treatment or procedure indicates and describes below.

Fillings: Amalgam (silver) or Composite (tooth colored) without pin

Risks:
1. All risks involved with anesthesia
2. Thermal sensitivity for as long as 6 weeks
3. Tooth may die and abscess resulting in the need of a root canal or an extraction

Root canal: Nerve Treatment

Risks:
1. All risks involved with anesthesia
2. Unsuccessful root canal resulting in extraction of the tooth
3. If tooth is not crowned, it may fracture resulting in extraction
4. Swelling
5. Pain
6. Thermal sensitivity
7. Infection
8. Tooth may fracture during treatment
9. Surgical closure of apex of root
10. Broken file while instrumenting canal

Extraction

Risks:
1. All risks involved with anesthesia
2. Swelling
3. Phonetic interference (difficulty in speaking)
4. Cellulitis (infection)
5. Pain
6. Tooth mobility
7. Food impaction around extraction site
8. Trimus (temporary restricted mouth opening)
9. Stress on the jaw joints (TMJ) existing TMJ problems may be worsened
10. Allergic reactions (previously unknown to any of the medications used in the procedures
11. Tooth or fragment in maxillary sinus
12. Dry socket
13. Heavy bleeding that may be prolonged
14. Can fracture teeth on either side of tooth
15. Jaw fracture
16. Postoperative infection requiring additional treatment
17. Decision to leave a small piece in the jaw when its removal would require extensive surgery
18. Injury to the nerve underlying the teeth resulting numbness or tingling of the chin, lip, cheek, gum and/or tongue on the operated side; this may persist for several weeks, months, or in remote instances, permanently

Crowns, Bridges, and Veneers

Risks:
1. All risks involved with anesthesia
2. Death of the tooth resulting in the need of a root canal
3. Porcelain fused to metal may chip, or flake off
4. Thermal sensitivity
5. Loss of the tooth due to periodontal disease if tooth is not kept cleaned by the patient
6. Recession of the gum if the tooth is not kept by the patient
7. Chemical bond may not adhere (crown or veneer may come off)

Periodontal Treatment-Phase I: Oral Hygiene Instructions, Root Planning & Scaling

Risks:
1. All risks involved with anesthesia
2. Infection
3. Thermal sensitivity
4. Gum recession
5. Pain
6. Phonetic interference
7. Exposure of margins of crowns
8. Recurrence of gum problem if the patient does not concur with Oral Hygiene instructions

Periodontal Treatment-Phase II: Surgery

Risks:
1. All risks involved with anesthesia
2. Infection
3. Pain
4. Swelling
5. Thermal sensitivity
6. Gum recession
7. Exposure of margins of crowns
8. Phonetic interference
9. Tooth mobility
10. Food impaction between teeth
11. Trimus (temporary restricted mouth opening)
12. Recurrences of gum problems if the patient does not concur with Oral Hygiene instructions
13. Tooth will appear long due to removal of tissue

Anesthesia: May consist of one or both Nitrous Oxide (gas)

Risks:
1. Nausea and/or vomiting
2. Headache
3. Fainting
4. Death

Local Anesthesia: Infection of Lidocaine or Carbocaine

Risks:
1. Allergic reaction to anesthesia
2. Sweating
3. May lower or increase blood pressure
4. Fainting
5. Breakage of needle
6. Palpitations
7. Hermatoma (bruises)
8. Trimus (temporary restricted mouth opening)
9. Permanent or temporary parathesia (numbness)
10. Death

I certify that I have read and understand the above, I accept the risks of substantial and serious harm, I any if hope of obtaining the desires beneficial results of this treatment or procedures as checked above.

Patient or Parent of Minor	Date	Witness

WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date: _____

E-Mail Address: _____

Name: _____
Last First MI Mr. Mrs. Ms. Dr.

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ___/___/___ Age: ____ SS#: _____

Home Address: _____
Apt/Condo #

_____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (____)_____ Pager / Cell #: _____

Wk #: (____)_____ Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

2 SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Wk #: (____)_____ Ext: ____ SS #: _____

Birthdate: ___/___/___ DL #: _____

Person Responsible for Account: _____

Wk #: (____)_____ Ext: ____ Hm #: (____) _____

Billing Address: _____

Relationship: _____ SS #: _____

Employer: _____ DL #: _____

3 INSURANCE

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Neighbor or Relative not living with you.

His / Her Name: _____ Relation: _____

Wk #: (____)_____ Hm #: (____)_____

Address: _____

_____
City State Zip

4 MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (____)_____ Date of last visit: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

CONTINUED ON BACK

4 MEDICAL HISTORY CONTINUED

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one: _____

_____

Have you ever taken Phen-Fen? (Also known as Redux or Pondimin) ☐ Yes ☐ No
If so, when? _____

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems

Y N	Abnormal Bleeding	Y N	Herpes / Fever Blisters
Y N	Alcohol / Drug Abuse	Y N	High Blood Pressure
Y N	Anemia	Y N	HIV+ / AIDS
Y N	Arthritis	Y N	Hospitalized for Any Reason
Y N	Artificial Bones / Joints / Valves	Y N	Kidney Problems
Y N	Asthma	Y N	Liver Disease
Y N	Blood Transfusion	Y N	Low Blood Pressure
Y N	Cancer / Chemotherapy	Y N	Lupus
Y N	Colitis	Y N	Mitral Valve Prolapse
Y N	Congenital Heart Defect	Y N	Pacemaker
Y N	Diabetes	Y N	Psychiatric Problems
Y N	Difficulty Breathing	Y N	Radiation Treatment
Y N	Emphysema	Y N	Rheumatic / Scarlet Fever
Y N	Epilepsy	Y N	Seizures
Y N	Fainting Spells	Y N	Shingles
Y N	Frequent Headaches	Y N	Sickle Cell Disease / Traits
Y N	Glaucoma	Y N	Sinus Problems
Y N	Hay Fever	Y N	Stroke
Y N	Heart Attack	Y N	Thyroid Problems
Y N	Heart Murmur	Y N	Tuberculosis (TB)
Y N	Heart Surgery	Y N	Ulcers
Y N	Hemophilia	Y N	Venereal Disease
Y N	Hepatitis		

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Tetracycline
Y N Codeine	Y N Latex	Y N Other
Y N Dental Anesthetics	Y N Penicillin	

Please list any other drugs/materials that you are allergic to: _____

_____

5 DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Y ☐ N Do your gums ever bleed? ☐ Y ☐ N

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

How long do you use a toothbrush before replacing it? _____

Are your teeth sensitive to heat, cold, or anything else? _____

Have you lost any teeth? ☐ Yes ☐ No If yes, why? _____

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.

_____
Signature Date

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____
Signature Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

_____

MEDICAL HISTORY UPDATE

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date