HEALTH HISTORY

Name_____Date_____

Date of last health care exam:_____What was this exam for?_____

Have you been hospitalized in the last 5 years? Please circle YES / NO

If yes, reason:_____

Are you currently receiving care? No / Yes If yes, nature of care:_____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When Placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer? Or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychosis	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy	No	Yes
Fainting or Dizzy Spells	No	Yes	Rheumatic Fever	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve(artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Heart Stent? When Placed?	No	Yes	Venereal Disease	No	Yes
Other Conditions	No	Yes	Recurent Illnesses	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet(demetidine) or Prilosec(omeprazole)?	No	Yes
Antacids?	No	Yes	Cardizem(deltiazem) or Calan, Isoptin (Verapamil)?	No	Yes
Dilantin or Tegretol	No	Yes	Serzon (nefazodone)	No	Yes
Barbiturates (any)	No	Yes	Diflucan (fluconazole or Sporonox (itraconazole)	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Biaxin (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamaz, Aredia, Zometa, Actonel, Boniva)? If so, when did the treatment begin? When did treatment end?				No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Please list **any medications** you are currently taking and dosages:

1. _____
2. _____
3. _____
4. _____

Please list any **dietary or herbal supplements** you are taking, and for what purpose:

1. _____
2. _____
3. _____
4. _____

Women: Are you pregnant? No Yes
If no, are you planning pregnancy in the near future No Yes
Are you a nursing mother? No Yes
Are you taking birth control pills? No Yes

Abnormal **Blood Pressure**? No Yes
Have you ever received a diagnosis of " high blood pressure"?
What is your normal blood pressure? S /D Today:_____/_____

Are you **allergic** or have you had a reaction to:

a. Local anesthetics……No Yes
b. Penicillin or other antibiotics……No Yes
c. Aspirin, Ibuprofen or Tylenol……No Yes
d. Codeine, valium or other sedatives……No Yes
e. Other……No Yes

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes circle type: Smoke Chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

Weight and Diet Considerations

Weight	Meals per Day	Dietary Restrictions	Food Allergies

Sugar in your diet: (circle one): *none* *slight* *moderate* *high*

DOCTORS USE ONLY

Comments on patient interview concerning medical history:

Significant findings from questionnaire or oral interview:

Dental management considerations:

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_____ _____ _____
Patient (PRINT NAME) Patient Signature Date

_____ _____ _____
Doctor (PRINT NAME) Doctor Signature Date

JONES BRIDGE DENTAL CARE

An explanation of sedation, its purpose and benefits, the procedure and drugs used and the possible complications of its use as well as alternatives to its use were discussed with you at your consultation. We obtained your verbal consent to undergo this procedure. Please read this document, which restates issues discussed. Provide the appropriate signature on the last page. Please ask for clarification of anything you do not understand.

CONSENT FOR THE USE OF ORAL CONSCIOUS SEDATION ON:

_____

Name of Patient

ALTERNATIVE TYPES OF ANESTHESIA: I have been informed that my treatment can be performed with a variety of types of anesthesia: (1) local anesthesia as normally used for minor dental treatment; (2) local anesthesia supplemented with I.V. conscious sedation; (3) general anesthesia in the hospital or out-patient day care surgical center. I have been made aware that the risks with each type of anesthesia vary, with local anesthesia generally considered to have the lest risk and general anesthesia having the greatest risk. I have been advised that if I am significantly subject to fear, anxiety or emotional stress related to dental procedures, or if a long or stressful procedure is to be undertaken, or is certain medical or physical conditions exist, the risk sequence can change and I.V. conscious sedation, properly administered, might be beneficial relative to other anesthetics alternatives. I understand that, based on the doctor's judgment one or more of the choices for anesthesia may not be desirable in every case.

POSSIBLE RISKS AND SIDE EFFECTS: I have been informed and understand that occasionally there are complications associated with I. V. conscious sedation including, but not limited to: pain, hematoma (bruising due to leakage of blood from the vein), phlebitis (inflammation of the vein), infection, swelling, bleeding, numbness, discoloration, nausea, vomiting, allergic reaction, and in extremely rare instance intra-arterial injection with damage to the part of the body supplied by the artery, brain damage or death.

PATIENT COMPLIANCE: I agree to the following: (1) I will refrain from eating 8 hours prior to my dental appointment; (2) I will refrain from consuming alcoholic beverages for 12 hours before and 24 hours following this procedure; (3) I will disclose to the doctor any and all drugs and medications I am currently taking; (4) I have disclosed any abnormalities in my current physical status or past medical history including any history of drug or alcohol abuse or any abnormal reactions to any drugs/medications which I have taken; (5) I will arrange for a responsible adult to drive me home and be with me until the effects of sedation have worn off; and (6) I will refrain form driving motor vehicle or operation dangerous machinery for the remainder of the day I received sedation.

PATIENT'S ENDORSEMENT: My endorsement (signature) to this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied, and that after thorough deliberation, I give my consent for the performance of any and all procedures related to I.V. conscious sedation as presented to me during consultation and treatment plan presentation by the doctor or as described in this document.

Patient Signature Date

Witness Signature Date

Print Patient Name

CONSENT FOR ALTERATION AND ACCEPTANCE OF TREATMENT

I _____have agreed to the treatment described and have had all questions answered to my satisfaction. I understand that attempts have been made to include all possible scenarios of treatment that may be required. I also understand that unforeseen circumstances and esthetic considerations of the final restorations may/will occur during the course of treatment. If any change is required or approval and acceptance of the final restorations, I agree to:

_____Have my spouse/companion _____ informed of the change in treatment, all procedures, options, possible outcomes, and fees explained and I authorize this person to accept the changed treatment during my sedation. The above person may consent to the final placement and cementation of any restorations pertaining to esthetic considerations.

_____I consent to allow the treating doctor to exercise their professional judgment to proceed with proper required treatment cautioning toward the side of conservation. Also, the doctor has consent to make final judgment on cementation of restorations that pertain to esthetics. I understand that this may mean additional fees to my treatment.

_____I would like the treating doctor to stop treatment in the event of any change, and temporize any work in an acceptable manner. I will decide on treatment after my recovery and after new treatment, options, outcomes, and fees have been satisfactorily explained to me. I understand that this may result in additional appointment so complete treatment and possible additional fees.

This is an effort to maintain the established partnership in which everyone is an active participant in treatment. With an open exchange of information and mutual consent, we feel the best possible outcome will be achieved.

_____ _____

Patient Date

_____ _____

Assignee Date

_____ _____

Witness Date

JONES BRIDGE DENTAL CARE

BEFORE SEDATION INSTRUCTION

Just a reminder for you. We suggest you wear comfortable clothing e.g. a lightweight jogging suit. I know the timing may be complicated, but I assure you it is very important.

Your appointment is scheduled for: _____

You should not drink any alcohol or caffinated beverages for 24 hours prior to your appointment. You should also, not eat or drink anything for 8 hours before or should you take any medication not approved by Dr. Leo Yelizarov.

Take your Valium at bedtime if prescribed.

Take your Triazolam pill one (1) hour prior to your appointment as prescribed.

Have your companion bring you to our office at _____AM sharp.

Absolutely no driving before or after your sedation appointment. It is dangerous to yourself, as well as others. It can be fatal! Someone needs to bring you and take you home from your appointment and they must stay with you for 12 hours.

_____
(Initials)

_____	_____	_____
Patient (Print Name)	Patient Signature	Date

_____	_____	_____
Doctor (Print Name)	Doctor Signature	Date

JONES BRIDGE DENTAL CARE

AFTER SEDATION INSTRUCTION

Initial Below **Patient Name:_____**

_____PATIENT CANNOT DRIVE FOR 24 HOURS AFTER SEDATION

_____DO NOT OPERATE ANY HAZARDOUS DEVICES FOR 24 HOURS

_____A RESPONSIBLE PERSON SHOULD BE WITH THE PATIENT UNTIL SHE/HE HAS FULLY RECOVERED FROM THE EFFECT OF THE SEDATION

_____PATIENT SHOULD NOT GO UP AND DOWN STAIRS UNATTENDED. LET THE PATIENT STAY ON THE GROUND FLOOR UNTIL RECOVERED

_____PATIENT CAN EAT WHENEVER AND WHATEVER SHE/HE WANTS

_____PATIENT NEEDS TO DRINK PLENTY OF FLUIDS AS SOON AS POSSIBLE

_____PATIENT MAY SLEEP FOR A LONG TIME OR MAY BE ALERT WHEN SHE/HE LEAVES. ATTEND TO BOTH ALERT OR SLEEPY PATIENT IN THE SAME MANNER, DON'T TRUST HER/HIM ALONE

_____ALWAYS HOLD PATIENT'S ARM WHEN WALKING

_____CALL US IF YOU HAVE ANY QUESTIONS OR DIFFICULTIES. IF YOU FEEL THAT YOUR SYMPTOMS WARRANT A PHYSICIAN AND YOU ARE UNABLE TO REACH US, GO TO THE CLOSEST EMERGENCY ROOM IMMEDIATELY

Following most surgical procedures there may or may not be pain, depending on your threshold for pain. You will be provided with medication for discomfort that is appropriate for you. In most cases, a non-narcotic pain regimen will be given consisting of Acetaminophen(Tylenol) or Ibuprofen (Advil). These two medications TAKEN TOGETHER, will be as effective as a narcotic without any of the side effects associated with narcotics. If a narcotic has been prescribed, follow the directions carefully. If you have any questions about these medications interacting with other medications you are presently taking, please call our office first, then your physician and /or your pharmacist.

Office phone # 770-772-0606
Dr. Leo phone # 770-855-9515

MEDICATIONS: Take only when checked

- ☐ Amoxicilin – Fill prescription and take as directed
- ☐ Erythromycin – Fill prescription and take as directed
- ☐ Tylenol (Acetaminophen) – Take two every 4 hours
- ☐ Advil (Ibuprofen). – Take as directed for pain
- ☐ Lorotab – For PAIN ONLY- Take one every 6 hours
- ☐ Vitamin C – one 1000mg at every meal 3 times a day
- ☐ Co Q 10- 50 mg two times a day.
- ☐ Vicodin ES – Fill Prescription and take as needed for pain

JONES BRIDGE DENTAL CARE

AFTER SEDATION INSTRUCTION

Initial Below **Patient Name:_____**

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_____DO NOT OPERATE ANY HAZARDOUS DEVICES FOR 24 HOURS

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