

Patient Name _____

Date of Birth _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No
- Have you ever been hospitalized or had a major operation? Yes No
- Are you taking any medications, pills or drugs? Yes No
- Do you take, or have taken, Phen-Fen or Redux? Yes No
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes No
- Do you take, or have taken, Boniva, Fosamax, Actonel or any other medication for osteoporosis? Yes No

If yes to any of these, please explain: _____

WOMEN - Are you: _____

- Pregnant / Trying to get pregnant? Nursing?
- Taking oral contraceptives?

Are you allergic to any of the following? _____

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
- Other _____

Do you have, or have you had, any of the following? _____

- | | | | | |
|---|--|--|--|--|
| <input type="checkbox"/> Aids / HIV Positive | <input type="checkbox"/> Cold Sores / Fever Blisters | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Attack / Failure | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Stomach / Intestinal Disease |
| <input type="checkbox"/> Arthritis / Gout | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Trouble / Disease | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tired |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Herpes | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Fainting Spells / Dizziness | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Tumor or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Shingles | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sinus Trouble | |

Have you ever had any serious illness that are not listed above? Yes No If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient Signature _____ Date _____

Parent or Guardian Signature _____ Date _____

Patient Name _____ Date _____

I am being provided with this information and consent form so I may better understand oral conscious sedation. Before beginning, I want to be provided with enough information, in a way I can understand, to make a well-informed and confident decision regarding oral conscious sedation when provided with my dental treatment. I understand that I may ask any questions regarding oral conscious sedation.

NATURE OF ORAL CONSCIOUS SEDATION

Conscious sedation of the type produced by oral sedation agents such as triazolam, diazepam, lorazepam, midazolam, zaleplon, and hydroxyzine, have been proven to be useful in controlling the fears of many dental patients. The properties of these agents have allowed many patients to receive dental treatment in a safe, relaxed state with a reduction in the level of fear and anxiety. However, awareness and the ability to respond will be decreased. Like all medications, there are limitations and risks and absolute success of treatment with oral sedatives is variable and cannot be guaranteed.

Eligibility for treatment with oral sedatives is determined through information gathered during a consultation and screening appointment. While many individuals will qualify for treatment with oral sedatives, not all people are candidates for it. If this situation occurs, Dr. Dillner will discuss his findings along with other possible treatments or options as appropriate.

ALTERNATIVES TO ORAL CONSCIOUS SEDATION

I understand that the alternatives to oral conscious sedation are:

- No sedation. I may choose to have the necessary procedure performed under local anesthetic while being fully aware.
- Nitrous oxide sedation. I may choose to have the necessary procedure performed with nitrous oxide sedation, which provides relaxation and I will be generally aware of surrounding activities. The effects of nitrous oxide sedation can be reversed within five minutes with oxygen.
- Anxiolysis. I may choose to have the necessary procedure performed by taking a pill to reduce fear and anxiety.
- Intravenous sedation. I may choose to have the necessary procedure performed with intravenous sedation, in which an anesthesiologist would administer the sedative agent through a tube connected to a vein in my arm.

I have had an opportunity to ask questions about these alternatives and any other treatments I have heard or thought about, including:

Patient's Initials _____

RISKS OF ORAL CONSCIOUS SEDATION

I have been informed and fully understand that virtually all forms of medication, including oral sedatives, can have potential risks and side effects. I understand that oral sedatives can, among other effects, alter my judgment and work performance and I should plan accordingly.

I understand that with oral conscious sedation, I may experience relaxation or drowsiness, a reduced sense of fear or anxiety, increased tolerance to discomfort, an altered perception of time, tingling sensations, giddiness or lightheadedness, clumsiness or unsteadiness, nausea, and hallucinations or dreams. Less common side effects include blurred vision, memory loss (which may be desirable for dental treatment), or "rebound insomnia" for several days. Rare side effects include agitation, behavior changes, convulsions, hypotension, skin rash or itching, sore throat, fever, chills, unusual tiredness, increased heart rate, hyperactivity or weakness may occur. I understand that there is also a chance of having an allergic reaction to the sedation medication which may include sweating, itching, hives, redness of the skin or swelling.

I understand that if I experience any unpleasant effects, before or after the procedure, I should inform Dr. Dillner as soon as possible.

UNFORESEEN CIRCUMSTANCES

I understand that unforeseen circumstances may arise that may necessitate a decision being made regarding my treatment as the circumstances warrant in fulfilling the health-related, functional, and esthetic objectives set out in my treatment plan. I understand that I will be unable to make these decisions while being in a sedated state and have the right to designate an individual to make these decisions on my behalf. If I do not designate such a person, I authorize Dr. Dillner to use his professional judgment in making decisions regarding my treatment as the circumstances warrant in fulfilling the health-related, functional, and esthetic objectives set out in my treatment plan.

_____ Patient's Initials	<input type="checkbox"/> I authorize _____ to make any decisions regarding my treatment as the circumstances warrant in fulfilling the health-related, functional, and esthetic objectives set out in my treatment plan while I am in the sedated state. <input type="checkbox"/> I authorize Dr. Dillner to use their professional judgment in making decisions regarding my treatment as the circumstances warrant in fulfilling the health-related, functional, and esthetic objectives set out in my treatment plan while I am in the sedated state.
-----------------------------	---

PATIENT ESCORT

I understand that I will not be able to drive or operate machinery while taking oral sedatives and for 24 hours afterwards. Therefore, I understand that I will need to make arrangements for someone to drive me to and from my dental appointment while under the effects of oral sedatives.

_____ Patient's Initials	I designate the following person as my escort (who must be over 18 years of age): _____ <table border="0" style="width: 100%;"> <tr> <td style="width: 60%;">Name of Patient's Escort</td> <td style="width: 40%;">Escort's Phone Number</td> </tr> </table>	Name of Patient's Escort	Escort's Phone Number
Name of Patient's Escort	Escort's Phone Number		

ACKNOWLEDGEMENT

I have provided as accurate and complete medical and personal history as possible, including antibiotics, drugs or other medication I am currently taking, as well as those to which I am allergic. I will follow all treatment and post-treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including x-rays.

I realize that in spite of the possible complications and risks, I elect to proceed with oral conscious sedation. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of treatment.

I, _____, have received information about oral conscious sedation. I have discussed oral conscious sedation with Dr. Dillner and have been given an opportunity to ask questions and have them fully answered. I understand the nature of oral conscious sedation, alternate treatment options and the risks of oral conscious sedation.

_____ Patient's Initials	I wish to proceed with oral conscious sedation. I understand the risks and elect to have oral conscious sedation done by Dr. Dillner.
-----------------------------	--

Patient or Guardian Signature	Date
Treating Dentist Signature	Date
Witness Signature	Date

Our goal in providing you with oral conscious sedation is to complete your dental treatment while providing you with a relaxed, comfortable, and safe experience. In order to provide you with the best sedation experience possible, below are a list of important instructions regarding your oral conscious sedation appointment.

YOUR COMFORT

In order for you to have the most relaxed and comfortable sedation experience, it is recommended that you wear comfortable, light-weight clothing, preferably with short sleeves, and comfortable shoes. If you wear contact lenses, please refrain from wearing them on the day of your sedation appointment. Please leave your purse or wallet, your watch, and any other valuables at home or with your escort.

DIET

To ensure proper absorption of the oral sedative medications, you should have nothing to eat or drink for twelve hours prior to your sedation appointment. It is also important that you do not drink any alcohol or caffeinated beverages twenty four hours prior to your sedation appointment. You should not consume any grapefruits or grapefruit products for at least one week prior to your sedation appointment, as the chemicals in the grapefruit will affect the oral sedative medications.

SMOKING AND NARCOTIC DRUG USE

If you are a smoker, nicotine levels in your blood will affect your sedation experience. Therefore, it is recommended that if you smoke less than a half of a pack of cigarettes per day, refrain from smoking for twelve hours prior to your sedation appointment. If you smoke a half to one pack of cigarettes per day, refrain from smoking for eight hours prior to your sedation appointment. If you smoke one to one and a half of a pack of cigarettes per day, refrain from smoking for four hours prior to your sedation appointment. If you smoke more than one and a half of a pack of cigarettes per day, smoke right before coming to the office. If you currently take any type of narcotic drugs or recreational drugs, you cannot safely be sedated.

PATIENT ESCORT INSTRUCTIONS

It is essential that you have an escort drive you to and from your appointment. If not, we will not be able to proceed with your sedation appointment. It is also important that we provide your escort with instructions, so please make sure that your escort speaks with a member of our dental team prior to your appointment. Should your escort wish to remain at the office during your sedation appointment, a very comfortable lounge is available for their use.

MEDICATION INSTRUCTIONS

To help boost your system and aid in producing an excellent healing experience, it is recommended that you take 1000 mg of Vitamin C three times per day and take 50 mg Enzyme CoQ10 twice per day one week before your sedation appointment and continue this regimen for two weeks after the sedation appointment. Below are your instructions regarding the oral sedative medications.

The evening before your appointment take: _____

The morning of your appointment take: _____

ADDITIONAL INSTRUCTIONS

Should you have any additional questions or concerns during normal business hours, please contact our office at 620.327.2887. If you have questions or concerns outside of normal business hours, please contact Dr. Justin R. Dillner at 620.217.5094.

INSTRUCTIONS FOLLOWING ORAL CONSCIOUS SEDATION

Following the oral conscious sedation experience, please make sure that the patient gets adequate rest for the twenty four hours following the procedure. It is also very important for someone to stay with the patient until the patient has recovered from the effects of the oral sedative medications. To ensure the patient's safety as the patient recovers from the effects of oral sedative medications, the following instructions have been provided, so please read them carefully.

GENERAL INSTRUCTIONS

After the oral conscious sedation appointment, a responsible person should be with the patient until the patient has fully recovered from the effects of the sedation. Although the patient may seem alert when they leave the dental office, this may be very misleading, and under no circumstances should the patient be left alone. Always hold the patient's arm when walking and the patient should not go up and down stairs. The patient cannot drive or operate any hazardous devices for 24 hours following the oral conscious sedation appointment. The patient should not be left alone with young children for any period of time for 24 hours following the oral conscious sedation appointment.

DIET

Following the oral conscious sedation appointment, it is important for the patient to drink plenty of clear fluids and to begin a diet high in vitamins and protein as soon as possible.

POST-OPERATIVE MEDICATIONS

After the oral conscious sedation appointment, to help boost the patient's system and aid in post-operative healing, it is recommended that the patient continue taking 1000 mg of Vitamin C three times per day and take 50 mg of Enzyme CoQ10 twice per day for two weeks following the sedation appointment. It is also recommended that the patient begin a non-narcotic pain regimen consisting of a combination of acetaminophen and ibuprofen to help manage any post-operative discomfort. A combination of acetaminophen and ibuprofen is a very effective combination to help the patient obtain pain relief with minimal side effects.

ADDITIONAL INSTRUCTIONS

ACKNOWLEDGEMENT

I, _____, the patient escort for _____, have received the above listed instructions in caring for the patient following their oral conscious sedation appointment. I have had the opportunity to discuss these instructions with Dr. Dillner and have been given an opportunity to ask questions and have them fully answered.

I understand that I am to take the patient directly home and that I am to call the office at 620.327.2887 when the patient returns home.

Patient Signature

Date

Patient's Escort Signature

Date

Treating Dentist Signature

Date

Witness Signature

Date

Should you have any additional questions or concerns during normal business hours, please contact our office at 620.327.2887. If you have questions or concerns outside of normal business hours, please contact Dr. Justin R. Dillner at 620.217.5094.

ORAL SURGEON INFORMATION

Name: _____ Phone: _____
Address: _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____
Address: _____
Home Phone: _____ Cell Phone: _____
Insurance Company: _____ Group Number: _____

PATIENT DENTAL HISTORY

Date of Most Recent Periapical and Bitewing Radiograph of Area: _____
Date of Most Recent Bitewing Radiographs: _____
Date of Most Recent Full Mouth Series of Radiographs: _____
Date of Most Recent Panoramic Radiograph: _____
Radiographs have been: e-mailed to your office mailed to your office sent with the patient

REASON FOR REFERRAL

Please evaluate the patient for:

- Alveoplasty
- Apicoectomy
- Dental Implants
- Extraction
- Lesion Evaluation and Biopsy
- Orthognathic Evaluation
- Other: _____

APPOINTMENT INFORMATION

- An appointment has been scheduled with your office on _____ at _____ .
- An appointment was unable to be made, but the patient will be contacting your office to schedule an appointment.
- Please contact this patient for an appointment.

Thank you for providing excellent care to our patient.

If you need any additional information or would like to speak to Dr. Dillner regarding this patient, please contact our office at 620.327.2887.

Thank you for keeping us updated on the patient's progress. Please send any treatment progress reports to: Hesston Dentistry, P.O. Box 250, Hesston, KS 67062 or via e-mail at office@hesstondentistry.com.

Sincerely,

Dr. Justin R. Dillner and the Hesston Dentistry Team