Welcome to Aesthetic, Implant and Family Dentistry

Dennis P. Goehring, D.D.S., P.A.

Patient Information

Date_____

Patient Name _____

Address_____

City_____ State_____ Zip_____

E-Mail_____

Sex M F Age_____

Birthdate_____ SS#_____

Married Widowed Single Minor

Separated Divorced Partnered for____years

Patient Employer/School_____

Occupation_____

Employer/School Address_____

_____

Employer/School Phone_____

Spouse's/Partner's Name_____

Birthdate_____

SS#_____

Spouse's Employer_____

Whom may we thank for referring you?_____

Dental Insurance

Who is responsible for this account?_____

Relationship to patient_____

Date Employed_____

Name of Employer_____

Insurance Co._____

Group #_____

Ins. Co Address_____

City_____

State_____

Zip_____

How much is your deductible?_____

How much have you used?_____

Max. Annual Benefits_____

For your convenience we offer the following methods of payment. Please circle the option you prefer:

Cash Personal Check Discover

VISA Mastercard AMEX

I wish to discuss the office's payment policy.

Phone Numbers

Home ( )_____ Work ( )_____ Ext._____ Cell Phone ( )_____

Spouse's/Partner's Work ( )_____ Best time and place to reach you?_____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name_____ Relationship_____

Home ( )_____ Work ( )_____

Dental History

Name of Previous Dentist and Location_____ Date of last exam_____

1. Do your gums bleed while brushing or flossing? Y or N
2. Are your teeth sensitive to hot or cold? Y or N
3. Are your teeth sensitive to sweets or sours? Y or N
4. Do you feel pain to any of your teeth? Y or N
5. Do you have any sores or lumps in or near your mouth? Y or N
6. Have you had any head, neck or jaw injuries? Y or N
7. Have you ever had any of the following problems in your jaw? Y or N
   - Clicking Y or N
   - Pain (joint, ear, side of face) Y or N
   - Difficulty opening or closing Y or N
   - Difficulty in chewing Y or N
8. Do you have frequent headaches? Y or N
9. Do you clench or grind your teeth? Y or N
10. Do you bite your lips or cheeks frequently? Y or N
11. Have you ever had any difficult extractions in the past? Y or N
12. Have you ever had any prolonged bleeding following extractions? Y or N
13. Have you had any orthodontic treatment? Y or N
14. Do you wear partials? Y or N
    If yes, date of placement._____ Y or N
15. Do you want your teeth whiter? Y or N
16. Do you want your teeth straighter? Y or N
17. Are you interested in porcelain veneers? Y or N

-over-

Health History

Physician_____ Office Phone_____ Date of Last Exam_____

1. Are you under medical treatment now? Y or N
2. Are you taking any medication(s) including non-prescription medicine? Y or N
3. Have you ever taken Fen-Phen/Redux? Y or N
4. Do you use controlled substances? Y or N
5. Are you wearing contact lenses? Y or N

Place a mark on "yes" or "no" to indicate if you have had any of the following below:

	Yes	No		Yes	No
Heart Murmur/Rheumatic Fever	☐	☐	Liver Disease	☐	☐
Mitral Valve Prolapse	☐	☐	Hepatitis/Jaundice	☐	☐
Cardiomyopathy	☐	☐	STD's	☐	☐
Hypertension/High Blood Pressure	☐	☐	HIV/AIDS	☐	☐
Low Blood Pressure	☐	☐	Epilepsy/Convulsions	☐	☐
Heart Related Problems not Listed Above	☐	☐	Fainting/Siezures	☐	☐
Stroke	☐	☐	Bleeding Disorders/Von Willbrands	☐	☐
Asthma	☐	☐	Hemophilia	☐	☐
Systemic Lupus Erythmatosis	☐	☐	Anemia	☐	☐
Cardiac Pacemaker or a Prosthetic Valve	☐	☐	Cancer	☐	☐
Cardiac/Heart Arrythmias	☐	☐	Radiation Therapy	☐	☐
Emphysema	☐	☐	Osteoradionecrosis	☐	☐
COPD/Chronic Obstructive Pulmonary Disease	☐	☐	Tuberculosis	☐	☐
Hay Fever or Allergies	☐	☐	Glaucoma	☐	☐
Respiratory Breathing Problems not isted Above	☐	☐	Arhthritis	☐	☐
Easily Winded	☐	☐	Joint Replacement or an Implant	☐	☐
Diabetes	☐	☐	Thyroid Problems	☐	☐
Kidney Diseases	☐	☐	Stomach Problems/Ulcers	☐	☐
Recent Weight Loss or Gain	☐	☐	Smoke or Use any Other Tobacco Products	☐	☐
Frequently Tired	☐	☐	Are you Pregnant?	☐	☐

Medications

List any medications you are currently taking and the correlating diagnosis:_____

_____

_____

Pharmacy Name_____

Phone ( )_____

Allergies

Are you allergic to or have any adverse reactions to any of the following:

- ☐ Penicillin
- ☐ Local Anesthetic
- ☐ Sulfa Drugs
- ☐ Barbituates
- ☐ Sedatives
- ☐ Iodine
- ☐ Aspirin
- ☐ Metals (e.g.)
- ☐ Latex
- ☐ Other_____

Authorization and Release

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 authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the acutal bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient (or parent/guardian if minor)

Doctor's Notes_____

_____

_____

X_____

Doctor's Signature

Request and Authorization for Treatment or Surgery

I (we) voluntarily request Dr. Goehring and/or any dentist(s) working with him or designated as their assistant(s), to perform the following treatment(s)/procedure(s)/surgery:

IV sedation, x-rays, exam, fillings deep cleaning, and extractions

as previously explained to me, or other procedures deemed necessary or advisable to complete the planned operation.

_____ I understand that the purpose of the procedure/surgery is to treat and to possibly correct my diseased oral tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present condition will probably worsen in time and the risks to my health include, but are not limited to the following: swelling, pain, infection, cyst formation, periodontal (gum) disease, dental decay malocclusion, pathologic fracture of the jaw, premature loss of teeth and/or premature loss of bone. I have been informed of possible alternative methods of treatment, if any. Dr. Goehring has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such operative risks include, but are not limited to the following:

_____1. Postoperative pain, discomfort and facial swelling that may necessitate several days of home recuperation.

_____2. Postoperative bleeding that may be prolonged.

_____3. Injury to adjacent teeth, crowns or fillings.

_____4. Postoperative infection requiring additional treatment.

_____5. Stretching of the corners of the mouth with resultant cracking and/or bruising.

_____6. Restricted mouth opening for several days or weeks.

_____7. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.

_____8. Breakage (fracture) of the jaw.

_____9. Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth and/or tongue on the operated side; this may persist for several weeks, months, or I some instances, permanently.

_____10. Opening of the sinus (a normal cavity situated above the upper teeth), requiring additional surgery.

_____11. Need for additional surgical treatment.

_____12. Bruising to the skin of the face, neck and intraoral soft tissues.

_____13. Temporary or permanent pain, dysfunction of the jaw joint requiring additional treatment or therapy.

_____14. Other_____

_____ Even though anesthesia (general and local) and sedation (oral, inhalation and intravenous) involves additional risks for the protection from pain and discomfort during the operation, I consent to and request the administration of anesthesia and/or sedation under the direction of Dr. Goehring and the use of such anesthesia and/or sedation agents that he may deem advisable.

_____Just as there are risks and hazards in continuing my present dental condition, uncorrected, there are also risks and hazards

attendant to the performance of the surgical and/or diagnostic procedures planned for me. I realize that common side effects from the anesthesia or sedation may include nausea, vomiting, drowsiness and fatigue. Though not a complete list, other less common hazards may occur which include: allergic reactions, minor discomfort, and irritation to veins, blood clots, bruising of tissue, damage to vocal cords, tooth injury, paralysis, blindness and even death.

_____ Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or any other drugs. Thus, I have been advised not to work or operate any vehicle, automobile, hazardous device or participate in any activity requiring mental alertness while taking medications and/or drugs, or until fully recovered from effects of the same. I understand and agree not to operate any vehicle or hazardous device for at least 24 hours after my release from surgery or until further recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office or hospital for my care. I agree not to drive myself home after surgery and will have a responsible adult drive me home after my discharge and monitor my condition for a 24 hour period.

_____If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgement or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever he may deem advisable.

_____ No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Because of the individual patient differences, there exists a risk of failure, relapse, selective retreatment or worsening of my present condition despite the care provided. However, it is the doctor's opinion that therapy would be helpful and that a worsening of my condition would occur sooner without the recommended treatment.

_____ I understand and agree that all tissue removed, including teeth, may be submitted to the pathologist for examination, and authorize him or Dr. Goehring to dispose of such tissue at their discretion.

_____I have had the opportunity to discuss my past medical and health history, including and serious problems and/or injuries.

_____I agree to cooperate completely with the recommendations of Dr. Goehring while under his care, realizing that any lack of same could result in a less-than-optimal result.

I certify that I have had an opportunity to read and fully understand the terms, words and explanations within the above consent to operation; that all blanks or statements requiring insertion or completion were filled in; and that inapplicable paragraphs, if any, were stricken before I signed. I also state that I read and write in English.

_____ _____

Patient/Parent/ Guardian/Provider Date

_____ _____

Witness Date

_____ _____

Doctor Date

NOTICE OF HEALTH INFORMATION PRACTICES ACKNOWLEDGEMENT FORM

Goehring Dental

Practice Name

The attached notice describes how medical information about you may be used an disclosed and how you can get access to this information. Please sign this cover sheet acknowledging receipt of the policy and return it to the receptionist. Review the policy carefully and let us know if you have any questions or requests.

By my signature below, I acknowledge that I have received the Notice of Health Information Practices of Goehring Dental. I understand that the organization reserves the right to change their notice and practice and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions requested. I understand that I may revoke tis consent in writing, except to the the extent that the organization has already taken action in reliance thereon.

_____

Name of Patient

_____

Signature of Patient/Guardian/Caregiver/Provider

_____

Date

All patients must be NPO (nothing by mouth) for 6 hours prior to their appointment with no exception. Meaning, the patient is to have **NOTHING TO EAT 6 HOURS** before their scheduled appointment. If the patient has not followed the dietary guidelines we will be unable to perform the necessary treatment planned items and this appointment will be considered a broken appointment and a **FEE OF $750** will result. If you are unable to make your appointment and need to reschedule for any reason a **48 hour notice is required**. Any last minute changes in your appointment can affect you as well as other patients and we reserve the right to charge a **FEE of $750** if the proper notice is not given. If you have any questions please call our office at **(512)892-8822**.

By signing below, I understand and have read the above statement and agree to its terms and conditions.

_____ _____

Signature of Patient/Guardian/Caregiver Date

_____

Printed Name

Informed Consent for Anesthesia

The following is provided to inform patients of the choices and risks involved with having treatment under anesthesia. This information is not presented to make patients apprehensive, but enable them to be better informed concerning their treatment.

I hereby authorize and request Dr. Goehring and _____ to perform the anesthesia as previously explained to me, and any other procedures deemed necessary or advisable as a corollary to the planned anesthesia. I consent, authorize and request the administration of such anesthetic or anesthetics (local to general) by any route that is deemed suitable by the anesthesiologist, who is contracted through Eastern Medical Staffing. It is the understanding of the undersigned that the anesthesiologist will have full charge of the administration and maintenance of the anesthesia and this is an independent function from the surgery/dentistry.

The most frequent side effects of any IV anesthesia are drowsiness, nausea/vomiting and phlebitis. Most patients remain drowsy or sleepy following their surgery for the remainder of the day. As a result, coordination and judgement will be impaired for as long as 24 hours. It is recommended that patients refrain from activities such as driving, and that children remain in the presence of a responsible adult during this time period. Nausea and vomiting following anesthesia will occur in 10-15% of patients. Phlebitis is a raised, tender, hardened, inflammatory response at the intravenous site. The inflammation usually resolves with local application of warm moist heat, however, tenderness and a hard lump may be present up to a year.

I have been informed and understand that rarely there are complications of anesthesia including but not limited to: pain, hematoma, numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, pneumonia, stroke, brain damage, heart attack and death. I further understand and accept the risks that complications may require hospitalization. I have been made aware of the various risks associated with local anesthesia, conscious sedation and general anesthesia. Of these three, local anesthesia is usually considered to have the least risks and general anesthesia the greatest risk. However, it must be noted that local anesthesia sometimes is not appropriate for every patient and every procedure.

I understand that anesthetics, medications and drugs may be harmful to the unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility for informing the anesthesiologist of the possibility of being pregnant or a confirmed pregnancy with the understanding that this will necessitate the postponement of the anesthesia. For the same reason I understand that I must inform the anesthesiologist if I am a nursing mother.

Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of coordination which can be increased by the use of alcohol or other drugs. I have been advised not to operate any vehicle or hazardous device for at least 24 hours or longer until me or my child have recovered from the effects of the anesthetic, medications and drugs. I have been advised of the necessity of direct parental supervision of my child for 24 hours following anesthesia.

I have been fully advised and completely understand that alternatives to sedation and general anesthesia. I accept the possible risks, side effects and dangers of anesthesia. I acknowledge the receipt of and understand that there is no warranty and no guarantee as to any result or cure. I have had the opportunity to ask questions about mine or my child's anesthesia and I am satisfied with the information provided to me. It is also understood that the anesthesia services provided to me are completely independent from the operating dentist's procedure. The anesthesiologist assumes no liability from the surgery/dentistry performed while under anesthesia and that the dentist assumes no liability from the anesthesia performed.

Signed_____ Printed Name_____

Witness_____ Date_____