Patient's Name_____ **Age** _____ **Date** _____

Medical Information

Height _____ **Weight** _____

1. Have you been a patient in the hospital during the past year?..... Yes No
2. In the past two (2) years, have you had a serious illness requiring a physician's care? ..... Yes No

Physician's Name_____ **Dentist's Name** _____

3. List medications/drugs you are taking: _____

_____

4. List prior operations/hospitalizations:_____

_____

5. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Stroke	Yes No	Psychiatric Problems	Yes No	Hepatitis	A B C D No
Heart Disease or Attack ...	Yes No	Ulcers	Yes No	Liver Disease	Yes No
Angina Chest Pain	Yes No	Diabetes	Yes No	H.I.V. Positive/A.I.D.S.....	Yes No
Heart Murmur	Yes No	Thyroid Problems	Yes No	Venereal Disease	Yes No
High/Low Blood Pressure .	Yes No	Glaucoma.....	Yes No	Cold Sores/Fever Blisters .	Yes No
Mitral Valve Prolapse	Yes No	Cancer	Yes No	Blood Transfusion	Yes No
Heart Pacemaker	Yes No	Chemotherapy	Yes No	Hemophilia	Yes No
Heart Surgery.....	Yes No	Radiation Therapy.....	Yes No	Anemia	Yes No
Rheumatic Fever	Yes No	Lyme Disease	Yes No	Sickle Cell Disease.....	Yes No
Artificial Heart Valve	Yes No	Emphysema	Yes No	Bruise Easily.....	Yes No
Artificial Joints (hip, knee, etc.).	Yes No	Tuberculosis.....	Yes No	Epilepsy or Seizures.....	Yes No
TMJ (jawjoint) problems ..	Yes No	Asthma	Yes No	Fainting or Dizzy Spells.....	Yes No
Snoring/Sleep Apnea	Yes No	Allergies or Hives	Yes No	Drug Addiction	Yes No
Severe/Frequent headaches.	Yes No	Sinus Problems	Yes No		

6. Have you ever taken prescription medication for weight reduction (diet pills)?..... Yes No

6a Have you ever taken prescription medication for osteoporosis (bisphosphonate: Fosamax, Zoireta, Areta)? Yes No

7. Do you take health food supplements (ginkgo, St. Johns wort, vitamin E, ginseng)? ..... Yes No

8. Are you sensitive or allergic to any of the following medications?

Penicillin	Yes No	Codeine	Yes No	Latex	Yes No
Erythromycin.....	Yes No	Aspirin/Ibuprofen.....	Yes No	Local Anesthetics	Yes No
Tetracycline	Yes No	Tylenol/Acetaminophen ..	Yes No	Food (e.g. egg, soy)	Yes No
Sulfa	Yes No	Steroids	Yes No	Other_____	

9. Do you smoke?..... Yes No How much per day_____
10. Do you drink alcohol?..... Yes No How much per day_____

10a. Do you take recreational drugs?..... Yes No

11. Do you have or have you had any disease, condition or problem not listed?..... Yes No

If yes, please list: _____

FOR WOMEN ONLY: Are you taking birth control pills? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No If yes, what month? _____

I understand the above information is necessary to provide safe surgical treatment. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature *(or Parent if minor)*_____ **Date** _____

Consent for Surgery

This is my consent for Drs. Tyko, Daniel, Rogers, and any other surgeons who are working with them to perform oral surgery.

I understand that there are risks in any treatment or procedure, and that such risks include, but are not limited to, the following:

1. Postoperative discomfort and swelling that may require several days of home recuperation.
2. Heavy or prolonged bleeding.
3. Injury to adjacent teeth or fillings, ligaments, muscles and jaw joint (TMJ).
4. Postoperative infection requiring additional treatment.
5. Stretching of the corners of the mouth with cracking or bruising.
6. Breakage of the jaw or restricted mouth opening for several days or weeks.
7. Leaving a small piece of root in the jaw when its removal would require extensive surgery.
8. Injury to nerves in the bone and tissues resulting in numbness or tingling of the lip, chin, gums, cheeks, teeth and/or tongue. This may persist for several months or, in some instances, permanently.
9. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.
10. If intravenous medication is used, soreness and/or discoloration at the injection site, or along the vein.

Medications, anesthetics and prescriptions may cause drowsiness, lack of awareness and coordination, which can be increased by the use of alcohol or other drugs; thus I agree not to operate any vehicles, hazardous devices or work until fully recovered from the effects of taking medications or drugs.

I agree to cooperate with the recommendations of Drs. Tyko, Daniel, Rogers and their associates while I am under their care, realizing that any lack of cooperation could result in a less then optimum result.

I CERTIFY I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT AND AGREE TO THE PROPOSED TREATMENT

Patient Signature *(or Parent if minor)*_____ **Date** _____

Federal Privacy Notice Acknowledgement

Our Federal H.I.P.A.A. Privacy Notice provides information about how we may use and disclose protected health information about you; the patient rights section describes your entitlements under the law. You have the right to review our Notice before signing this Consent. You have the right to revoke this Consent, in writing. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Our practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (H.I.P.A.A.). By signing this form, you are acknowledging that:

- Protected health information may be disclosed e.g. for treatment, payment or health care operations per our Federal H.I.P.A.A. Privacy Notice, which you have the opportunity to review.
- The patient can ask to restrict uses of their information but we are obliged solely to comply within the parameters of the law.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may, at its discretion, condition treatment upon the execution of this Consent.
- The Practice reserves the right to change the Notice based on amendments to federal law.

Patient Signature *(or Parent if minor)*_____ **Date** _____