Patient's Name________________________ ❑Male ❑Female Age ________ Date __________

Medical Information

Height ________ Weight ________ BMI __________

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 ______________________

   Preferred Pharmacy for Rx: ______________________ Location: ______________________

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 Issue .... 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
7. Have you ever taken prescription medication for osteoporosis (bisphosphonate: Fosamax, Zoireta, Areta)? Yes No
8. Do you take health food supplements (ginkgo, St. Johns wort, vitamin E, ginseng)? .... Yes No
9. 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______________

10. Do you smoke? .... Yes No How much per day______________
11. Do you drink alcohol? .... Yes No How much per day______________
12. Do you take recreational drugs? .... Yes No
13. 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** ____________

SROS #105

Consent for Surgery

This is my consent for Drs. Tyko, 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, 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** ______________