Ayotunde Esho, DDS
631 E 42nd St Odessa, TX 79762
Phone: 432-260-9636
Fax: 432-614-0002

Patient Information

First:_____MI:___Last:_____ Preferred Name: _____ Gender: (circle) M F

Patient Birth Date: _____ Patient Social Security #: _____ Email Address: _____

Mailing Address:_____City:_____St:_____ Zip:_____

Phone:_____(cell/home) Work Phone:_____ Ext:_____ Employer: _____

Emergency Contact: _____Relationship: _____ Phone #: _____

Responsible Party - The following is: □ the patient's spouse □ the person responsible for payment

Name: _____ Birth Date:_____ Responsible Party SS#_____

Address: _____ Phone:_____ Employer: _____

Dental & Health Information

Do you have history of any of the following? Please check those that apply:

□ AIDS or HIV
□ Alcohol Abuse
□ Allergies
□ Anemia
□ Angina
□ Arthritis
□ Asthma
□ Bleeding Disorder
□ Blood Disease
□ Cancer
□ Chronic Cough w/blood
□ Dental Anxiety
□ Diabetes
□ Dialysis
□ Dizziness
□ Drug Abuse
□ Emphysema
□ Epilepsy
□ Excessive Bleeding
□ Fainting
□ Glaucoma
□ Head Injuries
□ Heart Disease
□ Heart Attack
□ Heart Murmur
□ Hepatitis (Type_____)
□ High Blood Pressure
□ High Cholesterol
□ Jaundice
□ Kidney Disease
□ Leukemia
□ Liver Disease
□ Low Blood Pressure
□ Mitral Valve Prolapse
□ Nervous Disorders
□ Pacemaker
□ Psychiatric Problems
□ Radiation Treatment
□ Respiratory Problems
□ Rheumatic Fever
□ Sexually Transmitted Disease
□ Seizures
□ Sinus Problems
□ Stomach Problems
□ Stroke
□ Thyroid Problem
□ Tuberculosis (TB)
□ Tumors
□ Ulcers
□ Smoke
□ Use Tobacco
□ Any type of Implant
□ Any type of Transplant
□ Any Artificial Joint *(knee, shoulder, hip, etc.)*

Women
□ Currently pregnant
If yes, # of weeks:_____
□ Nursing?
□ Taking Birth Control?
Note: Antibiotics may alter the effectiveness of birth control pills.

Are you Allergic to any of the following?
□ Aspirin □ Codeine
□ Dental Anesthetics
□ Erythromycin □ Sulfa
□ Latex □ Metals
□ Penicillin □ Tetracycline
□ Other:_____

Reason for this Visit: _____

How did you hear about our office? _____ Date of Last Dental Visit:_____

- Is your general health good? □ **Yes** □ **No** - Are you currently taking **ANY** blood thinners or Aspirin □ **Yes** □ **No**
- Have you been told by a doctor that you should be pre-medicated for dental treatment? □ **Yes** □ **No**
- Have you ever had any complications during or following dental treatment? □ **Yes** □ **No**
  If yes, please explain: _____
- Are you currently taking any medications? Please list: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? □ **Yes** □ **No**
  If yes, please explain:_____
- Are you now under the care of a physician? □ **Yes** □ **No** *Name of Physician:_____
  If yes, please explain:_____
- Is there any other information which we should know about your heath? □ **Yes** □ **No**

Patient's Signature _____Date _____

Informed Consent for General Dentistry

Please read and initial as appropriate:

1. **EXAMINATIONS** – I understand that my initial visit may require dental x-rays to complete my examination, diagnosis and recommended treatment plan. (Initials_____)

2. **MEDICATIONS** – I have to the best of my knowledge provided a list of my current medications and known drug allergies. I have been made aware of the fact that certain medications used in the dental setting including but not limited to sedatives, anesthetics, analgesics and antibiotics may be associated with allergic reactions. I understand that sedatives used in the course of my care may result in impaired judgement and have been instructed not to operate a vehicle or dangerous device until fully recovered (typically 12 hours after procedure). I understand that certain antibiotics can reduce the effectiveness of oral contraceptives and have been advised to take extra precautions while taking these medications. (Initials_____)

3. **CHANGES IN TREATMENT PLAN** – I understand that during the course of my treatment, certain incidental findings may necessitate a change in my original treatment plan. For example, a deep cavity originally planned for a filling may end up requiring a root canal or extraction. I authorize my dentist to make changes to my treatment as needed provided the indication has been discussed with me. (Initials_____)

4. **TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)** – I understand that while routine dental procedures do not cause TMD, prolonged mouth opening during certain dental procedures may cause a transient exacerbation of existing TMD symptoms. Should the need for treatment of TMD symptoms arise, I understand that I will be referred to a TMD specialist, the cost of which would be my responsibility. (Initials_____)

5. **PROPHYLAXIS/ CLEANING** – I understand that this type of treatment is preventive and limited to the removal of plaque and calculus on teeth surfaces in the absence of periodontal (gum) disease. (Initials_____)

6. **PERIODONTAL TREATMENT** – I understand that the presence of significant inflammation (redness) of the gum tissues with or without associated bone loss may be an indication of periodontal disease necessitating periodontal therapy (scaling and root planing). I have been made aware that unmanaged periodontal disease can lead to tooth loss and is associated with certain systemic conditions such as but not limited to uncontrolled diabetes, heart disease and pre-term labor. Treatment options have been provided and explained to me and I understand that my adherence to post-op and home care instructions as well as recommended re-care protocol will play a pivotal role in my overall treatment outcome. I understand that transient bleeding of the gums and tooth sensitivity though uncomfortable may accompany my treatment and if such symptoms persist have been instructed to contact the office. (Initials_____)

7. **FILLINGS** – I understand that in the presence of extensive decay or poorly supported tooth structure, my tooth may require additional treatment including root canal therapy, crown or both. I understand that large fillings may fracture if not adequately supported and care must be taken when chewing on a newly restored tooth for the first 24 hours. I have been made aware that transient sensitivity may accompany a new restoration and if symptoms persist or become unbearable, I have been instructed to contact the office. (Initials_____)

8. **CROWNS, BRIDGES, VENEERS** – I understand while advances in dentistry have come a long way, sometimes it may be difficult to replicate the natural tooth appearance with an artificial tooth. I also understand that while waiting on my permanent crown, bridge or veneer, I will be provided with a temporary prosthesis to preserve space and reduce symptoms of sensitivity to a minimum. I have been made aware that mild sensitivity may be associated tooth recently prepared for a crown, bridge or veneer and occasionally, temporary or permanent crowns, bridges or veneers may come off and require re-cementation. I understand that it is my responsibility to take care of my crown, bridge or veneer and that damage to my prosthesis outside of provider error necessitating a remake would attract a charge for which I would be responsible. I understand that it is also my responsibility to advise my dentist of all metal allergies as some crowns or bridges have a metal substructure. (Initials_____)

9. **BLEACHING** – I have been made aware that bleaching can be done either in-office (approximately one hour) or with customized take-home trays (several treatments at home over 2-4 weeks). I understand that the degree of whitening varies with individuals and the average patient achieves a change of 1-3 shades on the dental shade guide. I understand that colored drinks like coffee, tea, red wine or colored juiced or soda as well as tobacco will stain teeth and are to be avoided for at least 24 hours after treatment. I understand that mild teeth sensitivity may accompany teeth whitening and have been instructed to discontinue whitening if sensitivity becomes significant. (Initials_____)

10. **ENDODONTIC THERAPY (ROOT CANAL)** – I understand that root canal treatment though largely effective does not guarantee saving my tooth. I also understand that complications occasionally occur in the course of treatment including but not limited to: bleeding, pain, extrusion of instruments through canal, loss of tooth structure and loss of file pieces in canal, all of which may or may not affect treatment outcome. I understand that root fracture may be difficult to detect and could contribute to treatment failure. Further, I understand that certain canals may have become calcified (blocked off) and inability to gain access or fully treat may necessitate referral to a root canal specialist, the cost of which would be my responsibility. (Initials_____)

11. **EXTRACTIONS (TOOTH REMOVAL)** – Indication, alternative to tooth removal as well as potential consequences non-treatment have all been explained to me. I understand and authorize the dentist to remove any and all teeth indicated for extractions. I understand that complications may be associated with tooth removal including but not limited to: pain, swelling, infection, dry

socket, exposure of the sinuses, paresthesia (loss of feeling in teeth, lips, tongue or surrounding tissues which can last for an unspecified period of time) and jaw fracture. If complications do arise and are significant in nature, I have been instructed to contact the office immediately. I also understand that in the event of severe complications I may need further treatment by a specialist or even hospitalization, the cost of which would be my responsibility. (initials_____)

12. **IMPLANTS** – I understand that implant while a wonderful innovation are not permanent and ideal implant placement may not be possible due to anatomic limitations. I have been made aware that implant failure is always a possibility as a result of the body tissues recognizing artificial devices as foreign. I understand that complications may accompany implant placement such as bleeding, infections, trauma to the bone, nerve injury or jaw fracture. I understand the importance of adhering to the recommended periodic examinations and cleanings and agree to assume the responsibility of making appointments and reporting as instructed. (Initials_____)

13. **NITROUS OXIDE** – I have elected to have nitrous oxide with my dental treatment. I have been made aware of the financial implications as well as the possible side effects which include but are not limited to: nausea, vomiting, dizziness and headache. I understand that nitrous oxide use is contra-indicated in pregnancy. (Initials_____)

14. **DENTURES (COMPLETE AND PARTIAL)** – I understand that full or partial dentures are artificial devices made of acrylic, metal or porcelain. I understand that these devices are removable and the challenges associated with utilizing such devices have been explained to me. I have been given multiple opportunities to provide esthetic and structural input in the construction of my device. I understand that immediate dentures require several adjustments and relines to improve the fit as I heal after extractions and that I may require a permanent denture once healing and bone remodeling is complete. I understand that is my responsibility to keep my scheduled appointments as well as maintenance visits for denture cleanings. (Initials____)

15. **DENTAL BENEFITS** – I understand that my insurance provider may elect to only cover the minimum standard of care which may be contrary to my dentist's recommendation of optimal care. (Initials____)

Please refer to our FAQ link on our website (basindentalsuite.com) for more information.

Patient Signature: _____ **Date**: _____/_____/_____

Doctor's Signature: _____ **Date**: _____/_____/_____

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I, _____ , acknowledge that I have received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office has made it's NOTICE OF PRIVACY PRACTICES available to me.

_____ _____

Patient's Signature Date

_____

Print Legal Guardian's Name (If patient is a minor)

FOR OFFICE USE:

[ ] Patient/Guardian refused copy of the Notice of Privacy Practices (NPP).

[ ] Patient /Guardian refused to sign Acknowledgement of Notice of Privacy Practices.

_____ _____

Print Name (Office staff) Date

_____ _____

Signature Date