Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: _____ _____ _____ Home Phone: include area code _____ Business/Cell Phone: Include area code _____
Last First Middle

Address: _____ City: _____ State: _____ Zip: _____
Mailing Address

Occupation: _____ Height: _____ Weight: _____ Date of birth: _____ Sex: ☐ M ☐ F

SS # or Patient ID: _____ Emergency Contact: _____ Relationship: _____ Home Phone: _____

Cell Phone: _____

If you are completing this form for another person, what is your relationship to that person?

Your Name: _____ Relationship: _____

Do you have any of the following diseases or problems: (Check DK if you Don't Know the answer to the question	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information

For the following questions, please mark (X) your responses to the following questions.

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? ☐ DAILY ☐ WEEKLY ☐ OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam: _____
What was done at that time?: _____

Date of last dental x-rays: _____

What is the reason for your dental visit today? _____

_____

How do you feel about your smile? _____

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

Physician Name: _____ Phone: Include area code _____

Address / City / State / Zip: _____

If yes, what condition is being treated?

_____

_____

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐
Are you taking or have you recently taken any prescription or over the counter medicines?	☐	☐	☐

If yes, what was the illness or problem?

_____

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

_____

_____

_____

_____

Date of last physical exam: _____

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement - Have you had an orthopedic total joint (hip, knee, elbow, finger replacement? Date: _____ If yes, have you had any complications? _____	☐	☐	☐
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink in a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies - Are you allergic to or have you had a reaction to: To all **yes** responses, specify type of reaction.	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐

	Yes	No	DK
Metals	☐	☐	☐
Latex (rubber)	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food	☐	☐	☐
Other	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prothetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart Attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐

	Yes	No	DK
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Rheumatic heart disease			
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus			
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐

	Yes	No	DK
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures			
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Mental health disorders			
Specify: _____			
Recurring infections	☐	☐	☐
Type of infections: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss			
Sexually transmitted disease			
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? .....

Name of physician or dentist making recommendation: _____ Phone: _____

Do you have any disease, condition or problem not listed above that you think I should know about? .....

Please explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

COASTAL DENTISTRY

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA), provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Service. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for our care. Patient records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail or by any means convenient for the practice and /or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the patient and the practice.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ hereby consent and acknowledge my agreement to the terms set forth above and any subsequent changes in office policy.

_____ _____

Signature **Date**

_____ _____

Parent/Guardian Signature (if necessary) **Date**

COASTAL DENTISTRY

FINANCIAL POLICY

Thank you for choosing our office to provide your dental care. We appreciate your trust and look forward to working with you. In order to prevent any misunderstanding and to better serve you, we ask that all patients read and sign our **FINANCIAL POLICY**. If you have any questions, please ask the front desk.

1. ***VERIFYING INSURANCE:*** **As a courtesy to you,** we will verify your insurance for eligibility benefits prior to your appointment as well as any time that you notify us of a change in your coverage. The insurance companies do not guarantee payment based on the information that they provide us. **You are ultimately responsible** for knowing if there are any waiting periods for work to be performed. Any amounts on your treatment plans that are not covered by your insurance, are your financial responsibility.

2. ***PAYMENT:*** Payment is due **at the time of service.** Additionally, if you have a balance following an insurance payment from a previous visit, you will be expected to pay that amount as well. Once treatment is rendered, no refunds will be issued. If additional procedures are required during the course of treatment, the patient is responsible for the cost of additional treatment.

3. ***PAYMENT PLANS:*** Please see our staff at the front desk for details.

4. ***BALANCES:*** If your account balance exceeds 30 days, you will receive a notice informing you that your account is **overdue** If you do not pay your balance or arrange a payment plan within 10 days, your account will be turned over to a collections agency. If this happens, a **collection fee** (currently 39% of the balance) will be added to your account balance. The collection agency will report any unpaid balance to the major credit bureaus.

5. ***RETURNED CHECKS:*** There will be a **$30** fee for all returned checks. The amount of the check plus the fee must be paid within 10 days of notification by money order, cash or credit card. Once a check has been returned, this office will no longer accept personal checks for payment.

6. ***CANCELLATIONS/FAILED APPOINTMENTS:*** We request **24-hours notice** if you are cancelling an appointment.

*** Thank you for reading this information in full. Please sign below to acknowledge your understanding of the entire FINANCIAL POLICY. ***

Patient or Guardian Signature _____ **Date** _____

Patient or Guardian Name (Please Print) _____

Signature of Dentist _____ **Date** _____

COASTAL DENTISTRY

Please read and initial the items checked below & read and sign the section at the bottom of the form.

Patient Name _____

☐ **WORK TO BE DONE**

I understand that I am having the following work done (**X**) photos (**X**) x-rays (**X**) exam (**X**) cleaning (**X**) fluoride

☐ **SEALANTS**

I understand that I may receive sealants. Sealants are a protective coating material that is applied to the chewing surface of back molars to act as a protective barrier from acids and plaque. Sealants generally last for several years but occasionally require reapplication.

☐ **DRUGS AND MEDICATIONS**

I understand that local anesthetics, antibiotics, pain medications and other drugs can cause redness, swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction). I understand that not everyone reacts the same to medication and such reactions are not predictable.

☐ **CHANGES IN TREATMENT PLAN**

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures, a crown being required instead of a routing filling and an extraction being required due to a non-restorable tooth with gross decay or fracture. If this is the case, proposed changes will be explained to me. Any differences in fee will be authorized by me before any changes take place.

☐ **FILLINGS**

I understand that teeth can become or remain sensitive after having a filling placed. This can occur with either amalgam (silver) or composite (tooth colored) filling materials. Sensitivity may require additional treatment. Removal of deep decay can lead to an abscessed tooth requiring either a root canal or extraction. I understand that if I need additional treatment the cost is my responsibility.

I understand that dentistry is not an exact science and that reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. All of my questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient _____ **Date** _____

Signature of Parent/Guardian (if patient is a minor) _____ **Date** _____

Signature of Dentist _____ **Date** _____

Signature of Witness _____ **Date** _____

COASTAL DENTISTRY

Consent for Internet Communications

Patient Name: _____ _____ _____ _____

Last First MI Preferred Name

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or any other need to deactivate my ID due to security concerns

Who may we thank for referring you to Coastal Dentistry? _____

COASTAL DENTISTRY

Informed Consent for Philips Zoom Whitespeed Tooth Whitening

Introduction

My dentist has informed me that my teeth are discolored and could be treated by in-office whitening (also known as "bleaching") of my teeth. This information has been given to me so that I can make an informed decision about having my teeth whitened. I may take as much time as I wish to make my decision about signing this informed consent form. I have the right to ask questions about any procedure before agreeing to undergo the procedure.

Description of the Philips Zoom Whitespeed Whitening Procedure

Zoom Whitespeed whitening is a procedure designed to lighten the color of your teeth using a hydrogen peroxide mixture and a specially designed ultraviolet lamp. It produces maximum whitening results in the shortest possible time with minimum sensitivity. During the procedure, the whitening gel will be applied to your teeth for (3) 20-minute sessions. For the duration of the entire treatment, a plastic cheek retractor will be placed in your mouth to help keep it open and your gums will be covered with a barrier to ensure isolation from the hydrogen peroxide gel. Before and after the treatment a shade of your teeth will be assessed and recorded.

Alternative Treatments

I understand I may decide not to have the Philips Zoom treatment at all. However, should I decide to undergo treatment, I understand there are alternative treatments for whitening my teeth for which my dentist can provide me additional information including but not limited to Philips Zoom Whitepro Chairside and Philips Zoom DayWhite or NiteWhite Take-Home as well whitening toothpastes, other in-office or take-home whitening treatments, porcelain crowns, veneers, or composites.

Cost

I understand that the cost of my Philips Zoom Whitespeed whitening treatment is determined by my dentist. I understand that my dentist will inform me if there are any other costs associated with my Philips Zoom Whitespeed whitening treatment.

Risks of Consent for Treatment

I understand that:

- Existing issues should be treated before undergoing a whitening procedure
- Results will vary or regress due to a variety of circumstances
- Philips Zoom whitening treatments are not intended to lighten artificial teeth, caps, crowns, veneers or porcelain, composite or other restorative materials, and that these types of restorations may need to be replaced at my expense to match my newly whitened teeth
- Darkly stained yellow or yellow-brown teeth frequently achieve better results than people with gray or bluish-gray teeth
- Teeth with multiple colorations, bands, splotches or spots due to tetracycline use or fluorosis do not whiten as well, may whiten unevenly, may require additional whitening, or may not whiten at all.
- Previous orthodontic treatments may cause teeth to whiten unevenly if any resin from the treatment was not properly removed from the teeth, either due to residual resin remaining on the teeth or over polishing upon removal.

• Teeth with many filling or cavities may not whiten and are usually best treated with other non-whitening alternatives.
• It is recommended that those currently treated for a serious illness or disorder (e.g. immune compromised, AIDS, etc.) should consult a medical doctor before use.
• Philips Zoom treatment is not recommended for pregnant or lactating women
• Philips Zoom Whitening treatment is not recommended for patients under 18 years of age.

I understand that the results of my Philips Zoom whitening treatment cannot be guaranteed.
I understand that professional whitening is considered generally safe by most dental professionals. I understand that although my dentist has been trained in the proper use of the Philips Zoom whitening treatment, the treatment is not without risk.

I understand that some of the potential complications of this treatment include, but are not limited to:
Tooth Sensitivity and/or Pain: While sensitivity is rare with the Philips Zoom treatment, people with existing sensitivity, recession exposing root surfaces, exposed dentin, untreated caries, cracked teeth, abfractions, oral tissue injury, open cavities, leaking filings, or other dental conditions that cause sensitivity or allow higher penetration of the hydrogen peroxide into the tooth may find that those conditions increase or prolong tooth sensitivity or pain after a Philips Zoom whitening treatment.

Gum Burn – Improper placement of the liquidam barrier along the gingival margin may cause or result in inflammation of the gums due to exposure of a small area of the gum to the whitening gel. The inflammation or burn is usually temporary and will subside after a few minutes.

The safety, efficacy, potential complications and risks of Philips Zoom Whitespeed Whitening treatment can be explained to me by my dentist and I understand that more information on this will be provided to me upon my request. Since it is impossible to state every complication that may occur as a result of the Philips Zoom treatment, the list of complications in this form is incomplete.

The basic procedure of the Philips Zoom Whitespeed Whitening treatment and the advantages and disadvantages, risks and known possible complications of alternative treatments have been explained to me by my dentist and my dentist has answered all my questions to my satisfaction.

Signatures
By signing this document in the space provided I indicate that I have read this informed consent (or it has been read to me), I fully understand the entire document and the possible risks, complications and benefits that can results from the Philips Zoom Whitespeed Whitening treatment, and I give my permission for this treatment to be performed on me.

_____	_____
Patient's Signature	Date
_____	_____
Patient's Name (Printed)	Date
_____	_____
Dentist's Signature	Date
_____	_____
Dentist's Name (Printed)	Date

COASTAL DENTISTRY

Informed Consent for Philips Zoom QuickPro Tooth Whitening

Introduction

My dentist has informed me that my teeth are discolored and could be treated by in-office whitening (also known as "bleaching") of my teeth. This information has been given to me so that I can make an informed decision about having my teeth whitened. I may take as much time as I wish to make my decision about signing this informed consent form. I have the right to ask questions about any procedure before agreeing to undergo the procedure.

Description of the Philips Zoom QuickPro Whitening Varnish 5-Minute Procedure

Philips Zoom QuickPro in-office tooth whitening varnish is a procedure designed to lighten the color of my teeth using a unique two-layer application that consists of hydrogen peroxide gel and a unique sealant. The Philips Zoom QuickPro whitening varnish involves a 5-minute in-office application. During the procedure a plastic retractor will be placed in my mouth to keep it open, a thin bead of isolation material will be laid down along the gingival margin, then the whitening varnish is applied to my teeth followed by the application of the sealant. After the second layer is applied and has dried (total procedure time is about 5-minutes), the isolation material and the retractor is removed. I leave the office with the varnish on (nearly clear and tasteless) and after 30 minutes (I understand I am not to drink or eat during the 30 minute wear time) I either wipe or brush off the varnish. This procedure is intended to deliver a noticeably whiter smile.

Alternative Treatments

I understand I may decide not to have the Philips Zoom treatment at all. However, should I decide to undergo treatment, I understand there are alternative treatments for whitening my teeth for which my dentist can provide me additional information including but not limited to Philips Zoom WhiteSpeed Chairside and Philips Zoom DayWhite or NiteWhite Take-Home as well whitening toothpastes, other in-office or take-home whitening treatments, porcelain crowns, veneers, or composites.

Cost

I understand that the cost of my Philips Zoom QuickPro whitening varnish treatment is determined by my dentist. I understand that my dentist will inform me if there are any other costs associated with my Philips Zoom QuickPro whitening varnish treatment.

Risks of Consent for Treatment

I understand that:

- Existing issues should be treated before undergoing a whitening procedure
- Results will vary or regress due to a variety of circumstances
- Philips Zoom whitening treatments are not intended to lighten artificial teeth, caps, crowns, veneers or porcelain, composite or other restorative materials, and that these types of restorations may need to be replaced at my expense to match my newly whitened teeth
- Darkly stained yellow or yellow-brown teeth frequently achieve better results than people with gray or bluish-gray teeth
- Teeth with multiple colorations, bands, splotches or spots due to tetracycline use or fluorosis do not whiten as well, may whiten unevenly, may require additional whitening, or may not whiten at all.
- Previous orthodontic treatments may cause teeth to whiten unevenly if any resin from the treatment was not properly removed from the teeth, either due to residual resin remaining on the teeth or over polishing upon removal.

• Teeth with many filling or cavities may not whiten and are usually best treated with other non-whitening alternatives.
• It is recommended that those currently treated for a serious illness or disorder (e.g. immune compromised, AIDS, etc.) should consult a medical doctor before use.
• Philips Zoom treatment is not recommended for pregnant or lactating women
• Philips Zoom QuickPro 20% Whitening Varnish treatment is not recommended for patients under 18 years of age.

I understand that the results of my Philips Zoom whitening treatment cannot be guaranteed.
I understand that professional whitening is considered generally safe by most dental professionals. I understand that although my dentist has been trained in the proper use of the Philips Zoom whitening treatment, the treatment is not without risk.

I understand that some of the potential complications of this treatment include, but are not limited to:
Tooth Sensitivity and/or Pain: While sensitivity is rare with the Philips Zoom QuickPro 20% treatment, people with existing sensitivity, recession exposing root surfaces, exposed dentin, untreated caries, cracked teeth, abfractions, oral tissue injury, open cavities, leaking filings, or other dental conditions that cause sensitivity or allow higher penetration of the hydrogen peroxide into the tooth may find that those conditions increase or prolong tooth sensitivity or pain after a Philips Zoom whitening treatment.

Gum Burn – Improper placement of the liquidam barrier along the gingival margin may cause or result in inflammation of the gums due to exposure of a small area of the gum to the whitening gel. The inflammation or burn is usually temporary and will subside after a few minutes.

The safety, efficacy, potential complications and risks of Philips Zoom QuickPro Whitening Varnish treatment can be explained to me by my dentist and I understand that more information on this will be provided to me upon my request. Since it is impossible to state every complication that may occur as a result of the Philips Zoom treatment, the list of complications in this form is incomplete.

The basic procedure of the Philips Zoom QuickPro 20% Whitening Varnish treatment and the advantages and disadvantages, risks and known possible complications of alternative treatments have been explained to me by my dentist and my dentist has answered all my questions to my satisfaction.

Signatures
By signing this document in the space provided I indicate that I have read this informed consent (or it has been read to me), I fully understand the entire document and the possible risks, complications and benefits that can results from the Philips Zoom QuickPro 20% Whitening Varnish treatment, and I give my permission for this treatment to be performed on me.

_____	_____
Patient's Signature	Date
_____	_____
Patient's Name (Printed)	Date
_____	_____
Dentist's Signature	Date
_____	_____
Dentist's Name (Printed)	Date

COASTAL DENTISTRY

INJECTION INFORMED CONSENT

Please read and initial appropriate sections as designated

Name _____ Date _____

_____ This consent form is designed to verify that you have been satisfactorily informed and educated in respect to your injection treatment as well as any aftercare and possible side effects, so that you can make an educated decision as whether to have this procedure performed.

_____ I understand that Botox Cosmetic® is the trademark for the bacteria clostridium botulinum and is injected into specific muscles to cause temporary paralysis in an effort to reduce the appearance of frown lines, crow's feet, and other facial expression lines.

_____ I understand that Juvêderm® is from culturally derived purified sources, which are approved to be injected directly into specific wrinkle lines/furrows and/or skin depressions in an effort to reduce the appearance of frown lines, crow's feet, and other facial expression lines related to aging, sun damage, and/or muscle overuse.

_____ Although the results of these types of aesthetic dermatologic injections are usually dramatic and positive, I have been informed that it is not an exact science and that no guarantees can be made regarding expected results in any case. After multiple injections, it is also possible that your body may produce antibodies reducing the effectiveness of the treatment(s).

_____ I certify that I am not pregnant (if female) and that I have no significant neurological disease, asthma, HIV, and/or facial herpes. Also, to the best of my knowledge, I certify that I have no allergies or sensitivities and that I am not allergic to eggs/egg products or lidocaine.

_____ I understand that improvement in the areas injected typically occurs within ten days. If satisfactory results are not achieved within that timeframe, I understand that I can call to set up an appointment for re-injection/touch-up. Unless special arrangements have been made, there are charges for re-injection to cover the cost of materials. I understand that beyond (21) days after initial treatment I will be charged normal injection fees. Also, I understand that only one re-injection session is allowed per treatment.

_____ Injections of therapeutic solutions are made through extremely fine needles into the skin and superficial muscles. I understand that benefits are sometimes evident immediately after treatment, but typically develop within three to ten days afterward.

_____ I understand that side effects/complications are infrequent, but occasionally headache, slight swelling and/or bruising may occur after treatment(s) for a few minutes to several days after injection(s). Rarely, a muscle close to an injection site may be temporarily weakened for several weeks as a result solution migration in the injected tissue. I have been advised of the risks involved with therapeutic injections and of the alternative treatments including no treatment at all.

_____ I am aware that several treatments may be needed to attain the most desired results and that follow-up injections are inevitably necessary to maintain desirable results. The timeframe varies for each patient, but generally speaking, each completed treatment lasts for approximately three months.

_____ I understand that post-treatment instructions include avoidance of manipulation/vigorous rubbing of the treated areas as well as avoidance of vigorous physical activity for four hours post- treatment.

_____ I agree that this form constitutes full disclosure and that it supercedes any related previous communication(s). All of my questions have been satisfactorily answered and I am prepared to undergo the designated injection treatment(s).

Patient Signature_____ Date _____

Dentist's Signature_____

Date _____