BYRD
DENTAL GROUP
Timothy N. Byrd, D.M.D. & Associates

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PLEASE PRINT AND FILL OUT COMPLETELY.

PATIENT'S NAME_____ ADDRESS_____ APT#_____

CITY_____ STATE____ ZIP_____ PHONE-H_____ C_____ W_____ DOB_____

PATIENT'S SSN ____-____-____ SEX___ MARITAL STATUS____ EMPLOYER_____ OCCUPATION_____

Email_____

SUBSCRIBER'S NAME_____ ADDRESS_____ APT#_____

CITY_____ STATE____ ZIP_____ PHONE-H_____ C_____ W_____ DOB_____

SUBSCRIBER'S SSN ____-____-____ SEX___ MARITAL STATUS____ EMPLOYER_____ OCCUPATION_____

INS. CO_____PLAN NAME_____INS. PH_____RELATION TO PATIENT_____

MEDICAL HISTORY – Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible oral health care to you (or your child), it is necessary to have the following information. HAVE YOU EVER HAD OR HAVE:

		YES	NO
1.	Asthma, have fever sinusitis, or other allergies		
2.	Allergy to penicillin, aspirin, local or general anesthetic, or other drugs; specify:		
3.	Blood pressure or heart problems		
4.	Rheumatic fever or heart murmur		
5.	A pacemaker or open heart surgery		
6.	Diabetes, liver, kidney, thyroid, or lung problems,		
7.	Ulcers or stomach problems		
8.	Hepatitis or Jaundice		
9.	Epilepsy or nervous disorders		
10.	Bleeding or clotting disorders		
11.	Arthritis		
12.	Venereal Disease, Herpes		
13.	Acquired Immune Deficiency Syndrome (AIDS)		
14.	Any other illness		
15.	Do any wounds heal slowly or present complications?		
16.	Are you presently taking any medicine? Specify:		
17.	Are you presently under the care of a physician?		
18.	When was your last physical exam?		
19.	Have you ever been hospitalized? Date: Reason:		
20.	Have you had X-ray treatments or chemotherapy?		
21.	Are you presently on a diet?		
22.	Women ( ) Are you taking birth control pills? ( ) Are you pregnant?		

PATIENT SIGNATURE DATE DOCTOR SIGNATURE DATE

Please Complete Reverse Side

DENTAL HISTORY _____

DATE OF LAST DENTAL EXAM _____

DATE OF LAST FULL MOUTH X-RAY _____ WHERE TAKEN _____

	YES	NO
1. Have you had trouble from previous dental care?		
2. Do you have pain in your jaw or near your ears?		
3. Do you have any unhealed injuries or inflamed areas in or around your mouth?		
4. Have you experienced any growths or sore spots in your mouth?		
5. Does any part of your mouth hurt when clenched?		
6. Have you ever had Novocaine or other local anesthetic?		
7. Have you ever had Nitrous Oxide (laughing gas)?		
8. Have you ever had general anesthesia?		
9. Have you ever had any reaction or allergic symptoms to Novocaine, local or general anesthetics?		
10. Have you ever had any difficult extractions in the past?		
11. Have you ever had prolonged bleeding following extractions in the past?		
12. Do your gums bleed?		
13. Do you have a bad taste in your mouth or mouth odor?		
14. Have you ever had instructions on the care of your gums?		
15. Do you chew on only one side of your mouth? Is so, why?		
16. Do you habitually clench or grind your teeth during the night or day?		
17. Is any part of your mouth sensitive to pressures or irritants (hot, cold or sweets)?		
18. Are you interested in straightening your teeth? (If yes, ask us about **INVISALIGN**)		

Is there any other problem not covered above that you would like to discuss? _____

_____

_____

_____ _____

PATIENT SIGNATURE DATE DOCTOR SIGNATURE DATE

Please Complete Reverse Side

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To our patients:

Our mission is to deliver the highest quality of dental care in a warm, friendly environment. To accomplish this, we schedule each patient according to his or her personal needs. In order for our staff to provide each patient with the level of care needed, please observe the following office policy:

- A 24-business hour notice is required for canceling appointments. Failure to give a 24-hour notice will result in a broken appointment fee of $40.00.
- If you are more than 15 minutes late for an appointment, we may have to reschedule your appointment.
- Payment to our office is due at the time of service.
- Patients with PPO, Traditional and/or Indemnity Insurance, please be advised that we will file your insurance as a courtesy. In the event that your insurance company has not paid within sixty days after it has been filed, any unpaid charges will become the responsibility of the patient. It will likewise become the responsibility of the patient to follow up with the insurance company to procure payment after sixty days. Any dispute of payment is between the patient and the insurance carrier.
- Returned checks will incur a processing fee of $45.00.
- We will honor all fees listed on your treatment plan for a period of 30 days from this date. After 30 days, treatment will be subject to the current fees.
- Your signature indicates understanding and acceptance of the above policy, as well as financial responsibility for any unpaid balances.

_____(Patient/Guardian if under 18)

_____(Date)

GENERAL DENTISTRY
INFORMED CONSENT

CHART NUMBER _____

NAME _____

1. **WORK TO BE DONE**
I understand that I am having the following work done. Fillings ____, Bridges ____, Crowns ____, Extractions ____, Impacted teeth removed ____, IV Sedation ____, Root Canals ____, Other ____.

2. **DRUGS AND MEDICATION**
I understand that antibiotics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). (Initials ____)

3. **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. I give my permission to the Dentist to make all/any changes and additions as necessary. (Initials ____)

4. **REMOVAL OF TEETH**
Alternatives to removal have been explained to me (root canal therapy, crowns and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. (Initials ____)

5. **CROWNS, BRIDGES AND CAPS**
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation. (Initials ____)

6. **DENTURES - COMPLETE OR PARTIAL**
I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. (Initials ____)

7. **ENDODONTIC TREATMENT (ROOT CANAL)**
I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extended through the root which does not necessarily effect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). (Initials ____)

8. **PERIODONTAL LOSS (TISSUE & BONE)**
I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.
(Initials ____)

Signature _____ Date _____

Doctor _____ Witness _____