Patient Registration and Medical History

(Please Print)

Date: _____ Home Phone: _____

Patient: _____ _____ _____ _____
Last Name First Name M.I. Preferred Name

Street Address: _____ City: _____ State: _____ Zip Code: _____

Sex: ☐ M ☐ F Age: _____ Birth Date: ____ / ____ / ____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Spouse/Parent Name: _____ Spouse/Parent Birthdate: _____

Spouse/Parent Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Who is Responsible for this Account? _____ Relationship to Patient: _____

Social Security #: _____ Spouse/Parent Social Security #: _____

Name of Dental Insurance Company: _____ Group Number: _____

In Case of Emergency, Who Should be Notified? _____ Phone: _____

Whom May We Thank for Referring You? _____

MEDICAL HISTORY

Physician's Name: _____ Date of Last Physical: _____

Have you ever had any of the following? (check all boxes that apply):

- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves or Joints
- ☐ Recent Weight Loss
- ☐ Back Problems
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Chronic Diarrhea
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicines or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Arthritis
- ☐ Special Diet
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ "A.I.D.S." or Other Immunosuppressive Disorders
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemoplilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____ If so, what: _____

_____

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medication at this time? _____ If so, what? _____

Are you under the care of a physician? ☐ Yes ☐ No

For what conditions? _____

If patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history? _____

_____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ Signature: X _____

(OVER)

Assignment and Release

I, the undersigned, have insurance with _____,
Name of Insurance Company(ies)

and assign directly to C.E. Solano D.M.D. all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Payment Policy

Payments may be made with cash, check, Visa, MasterCard, Discover or American Express. For the convenience of our patients, the following alternatives for financial arrangements are offered:

1) If you do not have dental insurance coverage, payment in full is expected for each appointment as service is rendered.
2) We will accept payment for treatment directly from your insurance company for the percentage which the company will cover. You are responsible for providing our office with your insurance information. If we do not receive payment from the company within **six weeks** after completion of the treatment, you will be expected to pay for all dental services. In the event of duplicate payment, you will be reimbursed. ***Those fees not covered by insurance are the responsibility of the patient.***
3) Please be aware that the parent bringing a child to our office for dental care is legally responsible for payment of all charges.
4) Remember, even if you have insurance coverage, ***you are responsible for payment of your account.*** We will be happy to help you receive the maximum benefits available under your policy. However, please realize that the relationship is between you, the insured patient, and your insurance company. The office can make no guarantee of insurance coverage or benefits. Any estimate provided by this office is to be considered a ***guideline*** until the insurance payment has been received.
5) The undersigned agrees to be responsible for payment of services rendered. Additionally, in the event it is necessary to pursue legal action to collect the patient's account, the undersigned agrees to reimburse us for our legal expenses including our reasonable attorney fees and or reasonable collection fees.

Consent for Treatment, Use and Disclosure of Protected Health Information

I, the undersigned, consent to treatment, and authorize C.E. Solano D.M.D. (the clinic) to use and disclose my Protected Health Information for treatment, payment, and health care operations. I understand that for a more complete description of the Clinic's uses and disclosures of my health information, I have been given the opportunity to review the "Notice of Privacy Policies" (Notice). I may review the Notice prior to signing this consent form. I have the right to request a restriction on how my health information is used or disclosed for health care operations; however, the Clinic is not required to agree to any restriction. If the Clinic agrees to the restriction, it is binding on the Clinic except in an emergency situation or if disclosure is required by law. I understand this consent may be revoked in writing at any time except to the extent already acted upon. A photo static copy of this consent shall be considered as effective and valid as the original.

I have had the opportunity to review a copy of the "privacy policy" and do agree to the payment policy as written above:

X _____ _____
Signature Of Patient Or Authorized Representative *Date*

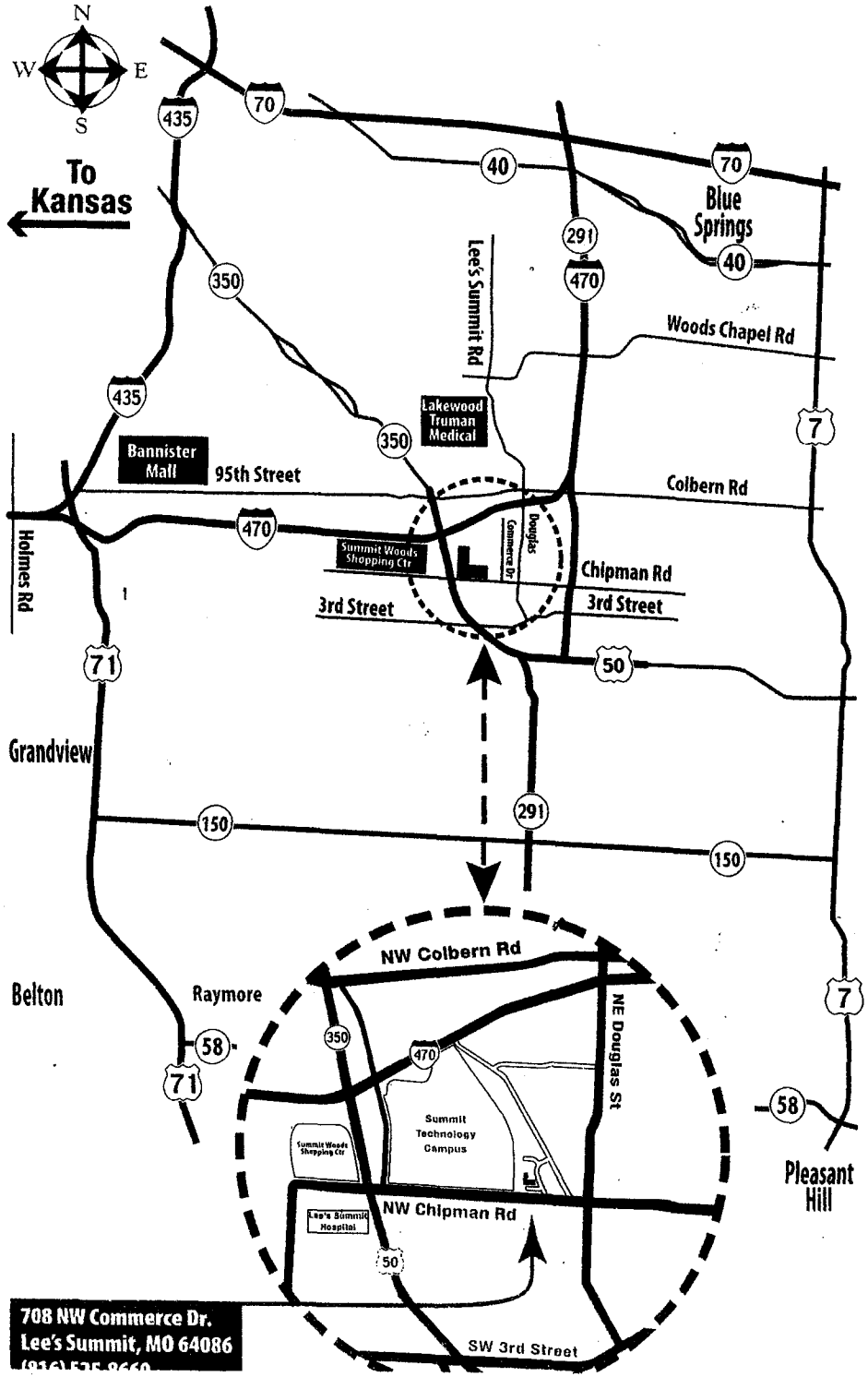
If authorized Representative, relationship to patient: _____

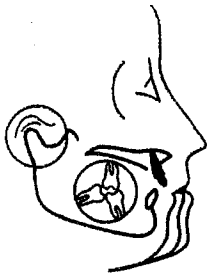
Minor/Child Consent

I, being the parent or legal guardian of _____
do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

X _____ _____
Signature Of Insured/Guardian *Date*

If you have any questions please feel free to ask.





C.E. Solano, D.M.D., P.C.
Oral and Maxillofacial Surgery

708 NW Commerce Drive
Lee's Summit, Missouri 64086

Telephone: (816) 525-8660
Phone answered 24 hours

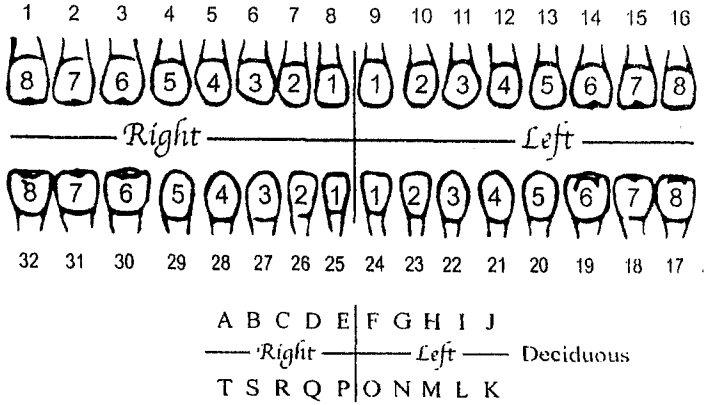
Date _____/_____

Introducing _____ Age _____

Consultation Regarding _____

Referred by _____

Teeth To Be Removed



INSTRUCTIONS FOR ALL PATIENTS

Call the office prior to your appointment if you have any questions. Bring a list of your current medications. If you have insurance, please bring your insurance card or insurance information.

PRE-OPERATIVE INSTRUCTIONS FOR GENERAL ANESTHETIC PATIENTS

MORNING appointments: **DO NOT eat or drink anything,** including water, after midnight the night before your appointment. It is okay to take your routine medications with a small sip of water. Please call the office if you have any questions regarding your medications.

AFTERNOON appointments: Before 7:00 a.m. you may have a light breakfast. You may drink water before 7:00 a.m. **ABSOLUTELY NOTHING TO EAT OR DRINK AFTER 7:00 a.m., including water and coffee.** It is okay to take your routine medications with a sip of water.

Patients must have an adult (minors need parent/legal guardian) to accompany them to appointment, able to drive you home and stay with you 8 to 12 hours following your surgery.

Please call the office with any questions.

Consent For Oral Surgery And Anesthesia

Please read the following carefully.
If you have any questions, please ask your doctor before signing this consent form.

I hereby consent for Dr. Solano and his staff to perform the following treatment/procedure/surgery:

_____

I understand that the purpose of the procedure/ surgery is to treat and possibly correct my diagnosed condition. The doctor has advised me that if this condition persists without treatment or surgery, my present status may worsen in time, and there may be risks to my health. I have been informed of possible alternative methods of treatment, if any. Dr. Solano has explained to me that there are certain inherent and potential risks in any treatment or procedure, and that in this specific instant such operative risks include, but are not limited to: post-operative discomfort and swelling, heavy or prolonged bleeding, injury to adjacent teeth or dental work, infection requiring additional treatment, damage to the lips, bruising, stress to the jaw joints resulting in restricted mouth opening or worsening of existing jaw joint problems, jaw fracture, possibility of the decision to leave a small piece of root if its removal would pose greater risks, injury to the nerves resulting in numbness or tingling of the chin/lip/cheek/gums/or tongue on the operated side (this may persist for several weeks, months, or in rare instances may be permanent), opening into the sinus requiring additional treatment, dry socket, allergic reactions or untoward reaction (previously unknown) to any medications used in the procedure, possibility of relapse/treatment failure/need for further surgery.

Other:_____

Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by alcohol or other drugs; thus I have been advised not to operate any vehicle, automobile or machinery until fully recovered from the effects of same. If sedative drugs have been given to me at the time of surgery, I agree not to drive myself home after surgery and will have a responsible adult drive me or accompany me home after my discharge from surgery. I understand that certain anesthetic risks which could involve serious bodily injury, are inherent in any procedure that requires a general or intravenous anesthetic. Recognizing that during surgery some unforeseen condition may be discovered that might necessitate a change in approach or different procedure from those explained above, I authorize Dr. Solano to perform such procedures as are necessary and advisable in the exercise of his professional judgement.

No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences, there exists a risk of failure, relapse, selective re-treatment, or worsening of my present condition despite the care provided. However, it is the doctor's opinion that treatment would be helpful, and that a worsening of my condition would occur sooner without the recommended treatment.

I have discussed my past medical history with my doctor and have disclosed all diseases and medications, including alcohol and drug use (past and present). If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgement or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever deemed advisable.

I agree to cooperate completely with Dr. Solano's recommendations, realizing that lack of cooperation may result in less than optimal result. I have not been given any warranty or guarantee as to the result of the proposed procedure.

WOMEN It has been explained to me, and I understand, that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, I understand that I will need to use some additional form of birth control, for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed.

I certify that I have had an opportunity to read and fully understand the terms within the above consent and the explanation made. I also state that I speak, read and write in the English language.

_____ _____
Patient (or legal guardian's) signature *Date*

_____ _____
Witness *Date*

_____ _____
Doctor signature *Date*

_____
Allergies

_____
Medications

_____
History

BP: _____ *X-Ray:* _____

Ref: _____ *Finger/point:* _____

C.E. Solano, D.M.D., P.C.
Oral and Maxillofacial Surgery

POST EXTRACTION INFORMATION

The following information is provided to help you through your postoperative care after tooth extraction. If any additional information is needed, call the office at 525-8660.

Bleeding - Some bleeding is to be expected. Normal bleeding may last from four to eight hours, with some oozing lasting up to 24 hours. ***Bite on a gauze pad placed over the extraction site for 4 - 6 hours after surgery.*** **DO NOT CHANGE GAUZE UNLESS NECESSARY** – frequent changing will only increase the bleeding or cause a dry socket. If bleeding persist, place a moistened tea bag (squeezed dry) over the area and bite down for 30 minutes – repeat this one or two times. Do not spit for the first 24 hours. Drink fluids with gauze pads in place if possible.

Swelling - Some degree of swelling is normal, depending on the amount of surgery done and the individual's response to it. Apply ice packs (wrapped in a thin towel) to the face at the extraction site for 15 minutes, then leave off for 15 minutes. Repeat as often as necessary for the first day. After the first 48 hours, warm, moist packs may decrease swelling. The most swelling usually occurs on the 2nd or 3rd day after surgery.

Discomfort - Some discomfort is expected following oral surgery. If you have been given a prescription for relief of pain, take one dose before the anesthetic wears off (this will allow the medication to begin to take effect before the local anesthetic wears off.) If no prescription was given to you, extra strength Tylenol® or Ibuprofen® should relieve the discomfort.

Diet - A soft liquid diet is best for the first one or two days following oral surgery. Try to chew on the opposite side of the extraction area(s). For the first two days, *avoid carbonated and alcoholic beverages, sucking through a straw and hot liquids*. Proper nourishment is important for good healing. Start drinking and eating as soon as possible. Taking medication on an empty stomach can produce nausea or vomiting.

Mouth Rinse - *Do not use mouth rinse or gargle for the 24 hours after tooth extraction*; this will allow proper formation of the blood clot in the extraction site. ***At the end of 24 hours, begin mouth rinses with warm salt water*** *(stir 1/2 teaspoon salt in a glass of warm water)* ***at least for 4 times a day,*** especially after eating. You may brush your teeth during this time but be sure to avoid the extraction site(s).

Smoking - *Do not smoke for the first 48 hours after extraction*. Smoking may interfere with blood clot formation and slow your healing process.

Driving - Depending on the time of your procedure and your individual reaction to the procedure you will probably want to relax for the rest of the day. Avoid driving, operating machinery or any decision making for at least 24 hour after your surgery *(if you have had IV drugs during your surgery)*. You will be very drowsy after surgery and should go home and rest with your head elevated on a pillow to minimize swelling, bleeding and discomfort.

Nausea / Vomiting - This is expected for the first 24 hours and is due to the IV or general anesthesia medications. If this persist after 24 hours, then the cause is due to pain medications or antibiotic given to you. Switch to a pain medication that you have taken in the past. If you want medications for nausea and vomiting (suppositories), a prescriptions can be called to your pharmacy. Have a pharmacy telephone number ready before you contact our office.

Medications - Take all regular medications as prescribed to you by your physician in addition to the medications that have been prescribed at the time of oral surgery. Antibiotics can interfere with the actions of birth control medications. Some other medications can also counteract each other. Check with your physician.

C.E. Solano, D.M.D., P.C.
Oral and Maxillofacial Surgery

Consent for Sedation / General Anesthesia
– Patient Identification –

Date: _____ Time: _____ ❑ AM ❑ PM

1) I, _____, authorize Dr. Solano or designated professional
patient or authorized representative
health care personnel to administer sedation / general anesthesia for my procedure. I understand and agree that the primary method of sedation will be general anesthesia / IV sedation. This method, as well as the alternative methods of sedation have been discussed with me in terms I can understand. If in the course of treatment, conditions dictate a change in medications, I understand and agree that changes will be made at the discretion of my physician or health care practitioner.

2. **Risks:** I give this authorization with the understanding that any type of medication involves some risks and hazards. The more common risks associated with the sedation / general anesthesia I will be receiving include: *allergic reaction, nausea, vomiting, itching, agitation, total amnesia and in rare cases, death.* I realize I may also have awareness during the procedure and / or later recall of the procedure. Due to my sedated state, I understand I also risk fluid or vomit entering my lungs that could cause serious breathing problems.

   Some additional significant and substantial risks of this type of sedation include, but are not limited to:

   _____ patient's initials _____

3. **Additional Procedure:** I also consent to any tests or treatments including the placement of invasive devices during the administration of sedation / general anesthesia or during the immediate recovery period which my physician determines necessary for my well being.

4. **Recuperative Period:** I understand that following the administration of sedation / general anesthesia my memory and decision making capacity may be impaired. I acknowledge that I have been instructed not to drive any vehicle or consume any alcohol for at least twenty-four (24) hours and not to take any medications not prescribed by my physician or health care practitioner. ***You must be accompanied by an adult.***

If you have any questions as to the risks or hazards of the proposed procedure or any questions concerning the proposed sedation, ask your physician / dentist now ***BEFORE SIGNING THIS CONSENT FORM****. You have the right to withdraw consent of this procedure at any time before it is performed.*

_____ _____
Signature of Patient or Authorized Representative *Witness*

_____ _____
Printed Name of Authorized Representative *Relationship to Patient*

_____ _____
Signature of Physician or Authorized Person Obtaining Consent *Interpreter*

PHYSICIAN AFFIRMATION: I Have Explained the Procedure Indicated Above and Its Attendant Risk, Benefits and Alternatives to the Patient Who Has Indicated Understanding Thereof, and Has Consented to Its Performance.

_____ _____ _____ ❑ AM ❑ PM
Physician / Practitioner *Date* *Time*

708 NW Commerce Drive Lee's Summit, Missouri 64086 (816) 525-8660