Butler Family Dental P.C.

Patient Information

Appointment Date: _____ Date of Birth:_____

Patient Name:_____

Address: _____

City: _____ State: _____ Zip: _____

Single: _____ Married: _____ Divorced: _____ Separated:_____ Widowed:_____

Phone: home (_____) _____ work (_____) _____
cell (_____) _____ Spouse's cell (_____) _____

Email: _____
Spouse's Name _____ Spouse's Date of Birth _____

Patient Employer: _____

Present Position_____ How long held _____

Spouse Employed By: _____

Present Position_____ How long held _____

Dental Insurance _____

ID#_____ Group # _____

Address: _____

City: _____ State: _____ Zip: _____

Patient Social Security # _____ Spouse Social Security #_____

****WE BILL INSURANCE AS A COURTESY; ALL PAYMENT IS DUE AT TIME OF SERVICE****

Who is responsible for this account? _____

Reason for this visit?_____

Who may we thank for referring you?_____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the information on this form to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information on this form as well as the Patietn Medical History form can be dangerous to my health. I authorize and request my insurance company to pay directly to the dentist or dental group, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependants.

X_____

Signature of Patient or Legal Guardian

Butler Family Dental P.C.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name_____

Address_____

Telephone_____Cell Phone_____

E-Mail_____Social Security #_____-_____-_____

_____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENT CAREFULLY

- **Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

- **Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice can be reviewed upon your request. We encourage you to read it carefully and completely before signing this Consent.

  We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

  You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time at:

  The Office of Butler Family Dental P.C.
  5406 W. Glenn Dr. Suite #2, Glendale, AZ. 85301
  Phone (623)937-2932 Fax (623)435-6921

- **Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the address listed above. Please understand that the revocation of this Consent will not affect any action we took in reliance on this Consent BEFORE we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I,_____, have had full opportunity to read and consider the contents of this Consent Form and the Notice of Privacy Practices. I understand that by signing this Consent Form, I am giving my consent to your use of and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature_____Date_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
INCLUDE COMPLETED CONSENT IN THE PATIENT'S CHART

Butler Family Dental P.C.

The following is a list of common risks and/or complications that may occur during and/or after dental treatment and/or dental surgery. The list does not itemize every possible risk and the patient or guardian is advised to seek a second opinion regarding any dental treatment that they do not fully understand. Please read this carefully and ask any questions that you may have concerning the treatment of yourself or your dependant. You should understand that since dentistry is not an exact science, no specific result is promised or guaranteed. Although the staff at Butler Family Dental does not expect you to suffer unnecessary complications, you are hereby advised that it is a possibility. Your signature on this form implies that you understand, to the best of your ability, and accept the risks and/or complications which may occur during your dental treatment, and acknowledge that they have been adequately explained to you in a manner which you understand, and that you realize the following list does not represent a complete explanation of every risk you may encounter in this or any other dental office.

1. X-rays are a form of radiation and should be avoided during pregnancy. If you ever visit this office while pregnant or are suspicious of a pregnancy, it is your responsibility to notify Butler Family Dental and REFUSE x-rays. Since most dental procedures are diagnosed and treated with the aid of x-rays, you must understand that we will require you to receive x-rays for most of the procedures we provide. A lead apron has been provided for your use and protection.
2. The administration of local anesthetic will make you numb for 1-6 hours. You should bite carefully to prevent injuring yourself during this time. It may leave you with soreness or discomfort at the injection site from several minutes to several days. If this is unacceptable, then you should request that minor treatment be preformed without anesthetic, or reschedule your appointment for a time when this discomfort is not going to be a problem.
3. A routine injection may injure or sever a nerve, leaving you with long-term or permanent anesthesia or parathesia. A routine injection may also puncture a blood vessel, causing hemorrhage or hematoma. If this occurs, call this office. Further treatment may be necessary from Butler Family Dental or a dentist of their choice.
4. Extraction of an erupted or impacted tooth or root tip may result in the same symptoms as described in item #3. Occasionally root tips break during an extraction. If this occurs they are usually removed, however, these root tips are sometimes left intentionally if it is determined that the risk of removal outweighs the risk of leaving them in place. Extraction of an upper tooth may result in loss of all or part of the tooth into the sinus cavity requiring further surgery by Butler Family Dental or a dentist of their choice. It is possible for an upper tooth to be successfully extracted while still opening an oral/antral fistula into a sinus. If your sinus is exposed, you will likely require further surgery by Butler Family Dental or a dentist of their choice. In the event either of these surgical procedures is required, you should avoid sucking on straws or blowing up balloons (or similar activities) for at least 6-8 weeks. If you feel unexplained air pressure leaking between your mouth and sinuses after an upper extraction, YOU are EXPECTED to call this office.
5. Extraction of an ankylosed tooth is ALMOST NEVER predictable and ALMOST ALWAYS requires the removal of a considerable amount of surrounding bone. Usually, such a large socket is NEVER completely filled back in with new bone and may result in noticeable, permanent bone loss with an accompanied weakening of the facial bone. Even if an extraction is routine, it leaves a large socket and may render the bone more susceptible to fracture for 6-12 months or perhaps permanently. YOU are expected to take every precaution to prevent additional trauma to this area. The instruments and/or forces used to extract a tooth may fracture the tooth, the bone, a nearby tooth or an adjacent restoration, requiring additional treatment by Butler Family Dental or a dentist of their choice.
6. Teeth are often filled or crowned with gold, silver or other substances, which conduct hot, cold and other stimuli extremely well. Most teeth are sensitive from three days to three weeks; however, some teeth are sensitive much longer or permanently. If your sensitivity persists, you will likely require pulpal treatment or root canal therapy by Butler Family Dental or a dentist of their choice. This sort of sensitivity generally results from large carious lesions, large restorations, large immature pulpals, hairline cracks or reduction for fixed prosthetics; this also has been shown to occur for no known reason.
7. Teeth that are crowned are often teeth that have fractured or have been repeatedly filled. Even a perfectly healthy tooth must be substantially reduced to receive a crown. This is particularly true with tipped, crooked or mal-occluded teeth. This reduction may cause sensitivity and can lead to future pulpal treatment or root canal therapy. Teeth that have been crowned NEVER have perfect margins. As you age, or your gingival tissue recedes, the margin is exposed and may cause the tooth to be more sensitive. In some instances, the pulp must be treated and/or the crown replaced. Porcelain behaves like glass and is easily fractured by hard foods or a blow to the mouth. Some long fixed bridges flex enough to fracture the porcelain covering. Fractured porcelain prosthesis is seldom repairable. Butler Family Dental does not accept responsibility for fractured porcelain since it is OUT OF THEIR CONTROL. The PATIENT is, however, advised that the metal jacket coping adequately protects the tooth with or without the porcelain covering.
8. Pulpal treatment or root canal therapy involves the placements of tiny fragile instruments into a tiny, often restricted, canal. These instruments can and do occasionally fracture inside the tooth. If this occurs, your attending dentist at Butler Family Dental may attempt to remove the instrument or refer you to an Endodontist to have it removed. If it is not able to be retrieved, we will advise you of its presence. In many cases, the fractured piece actually seals the canal, so no further treatment is needed. While fitting a root canal, it is possible to extrude gutta percha or root canal cement beyond the apex of the tooth. Even during routine root canal therapy, it is possible for painful symptoms to persist. If symptoms persist following any of these circumstances, you will likely require a surgical apio-ectomy and/or retro fill that may be preformed by Butler Family Dental or a dentist of their choice. If the symptoms are not relieved, then it is likely that the tooth will require EXTRACTION.
9. Removable dentures and partial dentures are plastic and/or metal appliances that, at best, are uncomfortable, clumsy and feel loose. Because they are not cemented into place, they rub on your gingival tissue and cause frequent sore spots. Clasps on partial dentures rub on adjacent teeth and cause scarring and lateral torque. A partial clasp can cause food traps, periodontal disease, tooth decay and loss of teeth. You are advised to keep these appliances as clean as possible and have them examined regularly in this office.
10. Crowns, fixed bridges, fillings, dentures, root canals and most other dental treatments are the dentists attempt to correct or prevent dental disease. These forms of treatment are not intended to be a substitute for healthy teeth, but rather a substitute for unhealthy and/or missing teeth. Dental treatment is not always successful at first. Some teeth or appliances need to be re-treated or treated differently and some DO NOT respond favorably to any treatment and are eventually extracted. Dental treatment may succeed at first and then suffer recurrent caries, fractures, abscess or pain in the future. You should visit this office no less than once per year to give Butler Family Dental the greatest possibility of serving you. You are encouraged to call if you ever have questions or complaints about your treatment. You will find our staff eager to make you comfortable.
11. Some patients present to the dental office with compromising health conditions. A history of A.I.D.S., heart disease, rheumatic fever, bleeding disorders, liver disease, hepatitis, kidney disease, diabetes, lung disease; or an allergy of sensitivity to penicillin, erythromycin, codeine, Percodan, Hycodaphen, aspirin, Tylenol, Empirin, Xylocaine, Carbocaine or Novocaine, may qualify you as an unjustified risk for this office. YOU are expected to circle any of the above conditions for which you are EVEN SUSPECTED of having, and notify Butler Family Dental in person. FAILURE TO DO SO, COULD RESULT IN SERIOUS INJURY OR DEATH. If you have a history of heart disease or other serious ailment, you will be required to have your physician consult with Butler Family Dental to determine whether or not you can be safely treated in this office. Even when precautions are taken, it is possible that you could suffer and exacerbation of your condition and/or any of its related complications.
12. Prescribing medications is routine in a dental practice. Antibiotics are prescribed for the control of infection; narcotics and non-narcotic analgesics are prescribed for the control of pain. Sedative /hypnotics are sometimes prescribed for the control of anxiety. Fluoride tablets and rinses are prescribed for caries reduction.

Butler Family Dental P.C.

MANY OF THE PRESCRIPTIONS WRITTEN IN THIS OFFICE CAN AND DO REACT UNFAVORABLY WITH MANY OTHER MEDICATIONS. If you are taking other medications at the time you are offered a prescription, YOU are EXPECTED to remind Butler Family Dental of all medications you are then using. If you are using or abusing controlled substances, marijuana, narcotics or any other drug(s), YOU are expected to give this information to Butler Family Dental each time you receive a prescription from this office so that we may substitute the medication or alter its dosage appropriately. FAILURE TO DO SO COULD RESULT IN DEATH OR SERIOUS INJURY. Antibiotics often render birth control pills ineffective; appropriate precautions must be taken during antibiotic therapy.

I do hereby acknowledge that I have been informed, to my satisfaction, of the risks and/or complications of the dental treatment which Butler Family Dental and/or Associates is to provide for me (or my dependant), and I do voluntarily assume those risks for myself (or my dependant). I do so agree to the mediation/arbitration agreement as stated in this document.

_____ _____-_____-_____

Signature of patient/Guardian **Date**

_____

Printed Name of above Signature

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

INCLUDE COMPLETED CONSENT IN THE PATIENT'S CHART

Butler Family Dental P.C.

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○ Yes ○ No _____

Are you on a special diet? ○ Yes ○ No

Do you use tobacco? ○ Yes ○ No

Do you use controlled substances? ○ Yes ○ No

Women: Are you

Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problem ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
			Yellow Jaundice ○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No _____

Comments: _____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____