# Medical Information

1. Have you been a patient in the hospital during the past year? ..... Yes No

2. In the past two (2) years, have you had a serious illness requiring a physicians care? ..... Yes No

   **Physician's Name** _____ **Dentist's Name** _____

3. List any medications or drugs you are taking. _____

4. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Stroke | Yes | No | Psychiatric Problems | Yes | No | Hepatitis | A B C D | |
| Heart Disease or Attack | Yes | No | Ulcers | Yes | No | Liver Disease | Yes | No |
| Angina Pectoris | Yes | No | Diabetes | Yes | No | A.I.D.S | Yes | No |
| Heart Murmur | Yes | No | Thyroid Problems | Yes | No | H.I.V. Positive | Yes | No |
| High/Low Blood Pressure | Yes | No | Glaucoma | Yes | No | Venereal Disease | Yes | No |
| Mitral Valve Prolapse | Yes | No | Cancer | Yes | No | Cold Sores/Fever Blisters | Yes | No |
| Heart Pacemaker | Yes | No | Chemotherapy | Yes | No | Blood Transfusion | Yes | No |
| Heart Surgery | Yes | No | Radiation Therapy | Yes | No | Hemophilia | Yes | No |
| Rheumatic Fever | Yes | No | Bisphosphonate Therapy | Yes | No | Anemia | Yes | No |
| Artificial Heart Valve | Yes | No | Emphysema | Yes | No | Sickle Cell Disease | Yes | No |
| Artificial Joints (hip, knee, etc.) | Yes | No | Tuberculosis | Yes | No | Bruise Easily | Yes | No |
| TMJ (jawjoint) problems | Yes | No | Asthmas | Yes | No | Epilepsy or Seizures | Yes | No |
| Lymes Disease | Yes | No | Allergies or Hives | Yes | No | Fainting or Dizzy Spells | Yes | No |
| Severe/Frequent headaches | Yes | No | Sinus Problems | Yes | No | Drug Addiction | Yes | No |

5. Have you ever taken prescription medication for weight reduction (diet pills)? ..... Yes No
   ❑ Fen-Phen (fenfluramine + phentermine) ❑ Pondimin (fenfluramine) ❑ Redux (dexfenfluramine)

6. Do you take health food supplements (ginkgo, St. Johns wort, vitamin E, ginseng)? ..... Yes No

7. Are you sensitive or allergic to any of the following medications?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Penicillin | Yes | No | Codeine | Yes | No | Latex | Yes | No |
| Erythromycin | Yes | No | Aspirin/Tylenol | Yes | No | Local Anesthetics | Yes | No |
| Tetracycline | Yes | No | Steroids | Yes | No | Other_____ | | |
| Food (e.g. egg, soy) | Yes | No | Allergies or Hives | Yes | No | | | |

8. Do you smoke? ..... Yes No How much per day_____

9. Do you drink alcohol? ..... Yes No How much per day_____

10. Do you have or have you had any disease, condition or problem not listed? ..... Yes No

    If yes, please list: _____

**FOR WOMEN ONLY:**

Are you pregnant? ❑ Yes ❑ No If yes, what month? _____ Are you taking birth control pills? ❑ Yes ❑ No
Are you nursing? ❑ Yes ❑ No

**I understand the above information is necessary to provide safe surgical treatment. I have answered all questions truthfully and to the best of my knowledge.**

**Patient Signature** *(or Parent if minor)* _____ **Date**_____

**Print Patients Name** _____

**Patient Name:** _____ **Age:** _____

# Consent for Surgery

This is my consent for Drs. Tolin, Tyko, Chu and Daniel and any other surgeons who are working with them to perform the following procedure(s).

I understand that there are risks in any treatment or procedure, and that such risks include, but are not limited to, the following:

1. Postoperative discomfort and swelling that may require several days of home recuperation.
2. Heavy or prolonged bleeding.
3. Injury to adjacent teeth or fillings, ligaments, muscles and jaw joint (TMJ).
4. Postoperative infection requiring additional treatment.
5. Stretching of the corners of the mouth with cracking or bruising.
6. Breakage of the jaw or restricted mouth opening for several days or weeks.
7. Leaving a small piece of root in the jaw when its removal would require extensive surgery.
8. Injury to nerves in the bone and tissues resulting in numbness or tingling of the lip, chin, gums, cheeks, teeth and/or tongue. This may persist for several months or, in some instances, permanently.
9. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.
10. If intravenous medication is used, soreness and/or discoloration at the injection site, or along the vein.

Medications, anesthetics and prescriptions may cause drowsiness, lack of awareness and coordination, which can be increased by the use of alcohol or other drugs; thus I agree not to operate any vehicles, hazardous devices or work until fully recovered from the effects of taking medications or drugs.

I agree to cooperate with the recommendations of doctors Tolin, Tyko, Chu & Daniel and their associates while I am under their care, realizing that any lack of cooperation could result in a less then optimum result.

**I CERTIFY I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT AND AGREE TO THE PROPOSED TREATMENT**

**Patient Signature** *(or Parent if minor)* _____ **Date**_____

# Federal Privacy Notice Acknowledgement

Our Federal H.I.P.A.A. Privacy Notice provides information about how we may use and disclose protected health information about you; the patient rights section describes your entitlements under the law. You have the right to review our Notice before signing this Consent. You have the right to revoke this Consent, in writing. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Our practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (H.I.P.A.A.). By signing this form, you are acknowledging that:

- Protected health information may be disclosed e.g. for treatment, payment or health care operations per our Federal H.I.P.A.A. Privacy Notice, which you have the opportunity to review.
- The patient can ask to restrict uses of their information but we are obliged solely to comply within the parameters of the law.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may, at its discretion, condition treatment upon the execution of this Consent.
- The Practice reserves the right to change the Notice based on amendments to federal law.

**Patient Signature** *(or Parent if minor)* _____ **Date**_____