DR. PAUL J. TIERNAN

PATIENT INFORMATION FORM

CIRCLE ONE: **Mr. Mrs. Ms. Miss Dr.**

Patient Name_____
Address_____
City _____ **State** _____ **Zip**_____
Home Phone _____ **Work/Cell** _____
Age ____ **Birthdate** _____ **E-mail**_____
If Student, School _____
SS# _____**Drivers Lic. #** _____
Referring Doctor _____

PRIVACY NOTICE

This offices privacy practices are in accord with HIPPA regulations. You may obtain a copy of our privacy practice at any visit. **Your signature here** indicates that you have been advised of the availability of this information.

X_____

Employer _____ **Employer Phone** _____
Business Address _____

PARENT/GUARDIAN INFO:
Name _____ Relationship _____
Birthdate _____ SS# _____ Drivers Lic.#_____
Employer _____
Address if different than above: _____
Contact phone if different than above**:** _____

IN CASE OF AN EMERGENCY CONTACT _____
Relationship to patient _____ **Phone #** _____

INSURANCE INFORMATION

We are billing your insurance as a courtesy to you. It must be understood that you are ultimately responsible for payment of the whole balance should your insurance company fail to fulfill its commitment.

Dental Primary
Insurance Co._____
Address _____
City _____State ____Zip _____
Phone# _____
Name of Insured _____
Insured Address _____
City _____State ____Zip _____
SS# _____D.O.B._____
Insured's Employer _____
Relationship to patient _____
Group # _____
ID# _____ Plan# _____

Dental Secondary
Insurance Co._____
Address _____
City _____State ____Zip _____
Phone# _____
Name of Insured _____
Insured Address _____
City _____State ____Zip _____
SS# _____D.O.B._____
Insured's Employer _____
Relationship to patient _____
Group # _____
ID# _____ Plan# _____

Please provide our staff with your MEDICAL CARD, so that a copy can be made and kept on file.

INFORMED CONSENT FOR ORAL SURGERY AND ANESTHESIA

This is my consent for **Dr. Paul J. Tiernan** to perform treatment/surgery: _____
_____
_____
as previously explained to me, or other procedures deemed necessary or advisable to complete the planned operation. I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral/maxillofacial tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably worsen in time, and the risks to my health may include, but are not limited to, the following: swelling; pain; infection; cyst formation; periodontal (gum) diseases; dental caries; malocclusion; pathologic fracture of jaw; premature loss of teeth; and/or premature loss of bone. I have been informed of possible alternative methods of treatment, if any:

1. _____ 2. _____ 3. _____

_____ 1. Postoperative discomfort and swelling that may necessitate several days of home recuperation.
_____ 2. Heavy bleeding that may be prolonged. Bruising of the tissue on the outside, in the mouth or outside of the face.
_____ 3. Injury to adjacent teeth, crowns and fillings, which may require repair, root canal therapy, or extraction.
_____ 4. Postoperative infection requiring additional treatment (including dry sockets).
_____ 5. Postoperative bone chips and spicules requiring additional surgery.
_____ 6. Stretching of the corners of the mouth with resultant cracking and bruising.
_____ 7. Restricted mouth opening for several days or weeks.
_____ 8. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
_____ 9. Breakage of the jaw, requiring treatment.
_____ 10. Injury to the nerve underlying the teeth resulting in numbness, tingling, or burning of the lip, chin, nose, gums, cheek, teeth and/or tongue on the operated side; this may persist for several weeks, months or, in remote instances permanent changes in speech and/or taste loss.
_____ 11. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.
_____ 12. Jaw joint problems (popping, clicking of the temporomandibular joint) or change in bite.
_____ 13. Inflammation, pain in the vein used to give intravenous medication.
_____ 14. Other
_____

_____ I agree and understand I am not to have and/or have not had anything to eat or drink for 6-8 hours before my surgery.

_____ I consent to administration of such local and/or sedation and/or general anesthesia as deemed necessary by **Dr. Tiernan**.

Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs; thus, I have been advised not to operate any vehicle, automobile or hazardous devices, or work, while taking such medications and/or drugs; or until fully recovered from the effects of same. I understand and agree not to operate any vehicle or hazardous device for at least twenty-four (24) hours after my release from surgery or until further recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office or hospital for my care. I agree not to drive myself home after surgery if sedation or general anesthesia has been
_____ administered, 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 anesthetic.
If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgment or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever he may deem advisable.

_____ 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 therapy would be helpful, and that a worsening of my condition would occur sooner without the recommended treatment.

I have had an opportunity to discuss with **Dr. Tiernan** my past medical and health history including any serious problems and health history including any serious problems and/or injuries. I agree to cooperate completely with the recommendations of **Dr. Tiernan** while I am under his care, realizing that any lack of the same could result in a less than optimum result.
I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT TO THE OPERATION AND THE EXPLANATION REFERRED TO OR MADE, AND THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED. I ALSO STATE THAT I READ AND WRITE ENGLISH.

Date	**Type of Anesthetic: Local, Sedation, General**	**Treatment and Surgery**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient's Signature
(Parent or Guardian if under 18 yrs.)
_____
_____
_____

DR. PAUL J. TIERNAN
ORAL AND MAXILLOFACIAL SURGERY

NAME: _____

MEDICAL QUESTIONNAIRE

Are you in good health?	Yes No
Date of your last physical exam _____	
Are you under the care of a physician?	Yes No
**** Name of Physician** _____	
**** If yes, what condition?** _____	
Have you had any serious illness or operation?	Yes No
Have you been hospitalized in the last 5 years?	Yes No
**** What was the problem?** _____	

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

HEART SURGERY	Yes No	**THYROID DISEASE**	Yes No
HEART FAILURE	Yes No	**PORPHYRIA**	Yes No
HEART ATTACK	Yes No	**CHEMOTHERAPY**	Yes No
HIGH BLOOD PRESSURE	Yes No	**RADIATION THERAPY**	Yes No
ANGINA PECTORIS	Yes No	**SICKLE CELL ANEMIA**	Yes No
HEART MURMUR	Yes No	**HEMOPHILIA**	Yes No
CONGENITAL HEART LESIONS	Yes No	**VON WILLEBRANDS DISEASE**	Yes No
ARTIFICIAL HEART VALVE	Yes No	**ANEMIA**	Yes No
IRREGULAR HEART BEAT	Yes No	**HEPATITIS A (infectious)**	Yes No
PACEMAKER	Yes No	**HEPATITIS B (serum)**	Yes No
RHEUMATIC FEVER	Yes No	**HEPATITIS (nonA nonB)**	Yes No
SCARLET FEVER	Yes No	**HEPATITIS C**	Yes No
CHRONIC/PERSISTENT COUGH	Yes No	**COLD SORES (oral herpes)**	Yes No
ASTHMA	Yes No	**GENITAL HERPES**	Yes No
EMPHYSEMA	Yes No	**AIDS OR ARC**	Yes No
TUBERCULOSIS	Yes No	**EPILEPSY OF SEIZURES**	Yes No
HAY FEVER	Yes No	**MUSCULAR DYSTROPHY**	Yes No
SINUS TROUBLE	Yes No	**MYASTHENIS GRAVIS**	Yes No
DO YOU SMOKE	Yes No	**STROKE**	Yes No
ARTIFICIAL HIP	Yes No	**GLAUCOMA**	Yes No
ARTIFICIAL KNEE	Yes No	**LIVER DISEASE**	Yes No
TMJ PROBLEMS (Pop or Click)	Yes No	**KIDNEY PROBLEMS**	Yes No
ARTHRITIS	Yes No	**ULCERS**	Yes No
DRUG ADDICTION	Yes No	**OSTEOPOROSIS**	Yes No
DIABETES	Yes No	**BISPHOSPHONATE HISTORY?**	Yes No

ARE YOU TAKING OR HAVE YOU TAKEN: ACTONEL, BONIVA, FOSOMAX, OR ZOMETA ?

Doctor's Notes: _____

Airway Classification MI MII MIII MIV MV

LIST ALL MEDICATIONS OR HERBAL SUPPLEMENTS YOU TAKE:

Name of medication	How often each day	Purpose or disease treated

DO YOU HAVE ANY ALLERGIES TO THE FOLLOWING:

LOCAL ANESTHETICS	Yes No
AMOXICILLIN/PENNICILLIN	Yes No
OTHER ANTIBIOTICS	Yes No
HOLISTIC MEDICINES	Yes No
BARBITUATES, SEDATIVES	Yes No
VALIUM	Yes No
DEMEROL	Yes No
CODEINE	Yes No

VICODIN	Yes No
OTHER NARCOTICS	Yes No
ASPIRIN	Yes No
IODINE	Yes No
EGGS OR SOY PRODUCTS	Yes No
LATEX	Yes No
OTHER:	Yes No
OTHER:	Yes No

Have you had psychiatric counseling?	Yes No
Do you have excessive nervousness or anxiety?	Yes No
Do you have fainting problems?	Yes No
Have you had serious trouble with past dental treatment?	Yes No
Have you taken a General Anesthetic or Sedation in the past?	Yes No
Have you or anyone in your family been advised of any complication during anesthesia? (Malignant Hypothermia)	Yes No
Does your employment expose you regularly to x-rays or other ionizing radiation?	Yes No
WOMEN: Are you pregnant?	Yes No
Are you practicing birth control?	Yes No

To the best of my knowledge, all of the preceding answers are correct. If I ever have any change in my health or my medications, I will inform Dr.Tiernan at my next visit.

_____

Date *Signature of Patient, Parent or Guardian (if under 18 years of age)*

Dates of Update: _____ _____ _____ _____

DR. PAUL J. TIERNAN
ORAL
AND
MAXILLOFACIAL
SURGERY

30 DOCTORS PARK DRIVE
SANTA ROSA, CALIFORNIA 95405
707-546-4727

Diplomate of the American Board of Oral and Maxillofacial Surgery

Fellow of the American Association of Oral and Maxillofacial Surgery

HIPAA PRIVACY OPTIONS

Patient Name_____ Date of Birth_____

Agreement to Receive Electronic Communication

I agree that Dr. Paul Tiernan's dental practice may communicate with me electronically at the email address below**. I am aware that there is some level of risk that third parties might be able to read unencrypted emails.** I am responsible for providing the dental practice any updates to my email address. I can withdraw my consent to electronic communications by calling **707-546-4727.**

Email address (PLEASE PRINT CLEARLY)
_____@_____

Release of Records

I give the office of Dr. Tiernan permission to contact my dentist or PCP as necessary for my treatment and to share my treatment records in regards to ongoing treatment. This release is valid for a period of two years from the date of signature.

Signed_____ Date_____

Permission to Share Information with persons other than dentist/physician:

I give the office of Dr. Paul Tiernan to share information regarding my appointments, treatment and financial responsibilities with the following people:

_____

_____

_____

Signed_____ Date_____

I may withdraw my consent to any of the above at any time by calling 707-546-4727.