PATIENT INFORMATION FORM

CIRCLE ONE: Mr. Mrs. Ms. Miss Dr. Patient Name	This offices privacy practices
Address City State Zi Home Phone Work/Cell Age Birthdate E-mail If Student, School SS# Drivers Lic. # Referring Doctor	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 Phone
	Relationship Drivers Lic.#
Contact phone if different than above:	
IN CASE OF AN EMERGENCY CONTACT	Phone #
INSURANCE IN INSURANCE IN Its are billing your insurance as a courtesy to you. It	

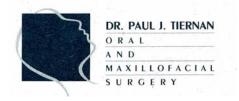
commitment.

Dental Primary		
Insurance Co		
Address		
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Name of Insured		
Insured Address		
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Dental Secondary		
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Insured Address		
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SS#	D.O.B	
Insured's Employer		
Relationship to patie	nt	
Group #		
ID#	Plan#	

INFORMED CONSENT FOR ORAL SURGERY AND ANESTHESIA

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 tech, 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, che teeth and/or tongue on the operated side; this may persist for several weeks, months or, in remote instances perman 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 1 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. 1 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 a least twenty-four (24) hours afform release from	that the purpose of advised me that if t and the risks to my (gum) diseases; den have been informed	the procedure/surgery is to tr his condition persists without health may include, but are no tal caries; malocclusion; path of possible alternative method	s deemed necessary or advisable to complete and possibly correct my diseased or at treatment or surgery, my present oral cost limited to, the following: swelling; pain tologic fracture of jaw; premature loss of ds of treatment, if any: 2	al/maxillofacial tissues. The doctor had not in the condition will probably worsen in time; infection; cyst formation; periodon teeth; and/or premature loss of bone in the condition of the cond
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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 healt	13. Inflamn	nation, pain in the vein used to	give intravenous medication.	
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Date Type of Anesthetic: Treatment and Surgery Local, Sedation, General Patient's Signature (Parent or Guardian if under 18 y	I agree and understated I consent to administ Medications, drugs, be increased by the hazardous devices, ounderstand and agree surgery or until furthe office or hospital administered, and we I understand that certain a general anesthetic If any unforeseen condition to or different No guarantee or assembly assembly as a satisfaction. Due to my present condition worsening of my cool I have had an opport health history included I CERTIFY THAT WORDS WITHIN MADE, AND THAT I READ AND THAT I READ	anesthetics and prescriptions use of alcohol or other drugs; or work, while taking such me se not to operate any vehicle other recovered from the effects of for my care. I agree not to drill have a responsible adult drugin anesthetic risks, which condition should arise in the content from those now contemplations are provided. Hondition would occur sooner with the care provided. Hondition would occur sooner with the care provided. Hondition would occur sooner with the care, realizing to a munder his care.	may cause drowsiness and lack of awaren thus, I have been advised not to operate a edications and/or drugs; or until fully recor r hazardous device for at least twenty-four of the anesthetic medication and drugs the rive myself home after surgery if sedation ive me or accompany me home after my dould involve serious bodily injury, are inhousted, I request and authorize the doctor to detail the proposed treatment will be curative there exists a risk of failure, relapse, selection to the exists a risk of failure, relapse, selection to the exists a risk of failure, relapse, selection to the exists a risk of failure, relapse, selection that the rithout the recommended treatment. Tran my past medical and health history in the exists and lack of the same could result in a trunity to read and the exist and lack of the same could result in a trunity to read AND FULLY UNITY TO READ AND FULLY UNITY TO READ AND THE EXPERENTS REQUIRING INSERTION APHS, IF ANY, WERE STRICKEN BI	deed necessary by Dr. Tiernan . The sess and coordination, which can my vehicle, automobile or vered from the effects of same. It is recall to the recall the same of the sa



NAME:	
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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 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:	
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LIST ALL MEDICATIONS OR HERBAL SUPPLEMENTS YOU TAKE:

Name of medication	How often each day	Purpose or disease treate

OU HAVE ANY ALLEKGIES IO THE FULLOWING:

LOCAL ANESTHE	TICS	Yes No
AMOXICILLIN/PE	NNICILLIN	Yes No
OTHER ANTIBIOT	TICS	Yes No
HOLISTIC MEDIC	INES	Yes No
BARBITUATES, SE	EDATIVES	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? Do you have excessive nervousness or anxiety? Do you have fainting problems? Have you had serious trouble with past dental treatment? Have you taken a General Anesthetic or Sedation in the past? Have you or anyone in your family been advised of any complication during anesthesia? (Malignant Hypothermia) Does your employment expose you regularly to x-rays or other ionizing radiation?

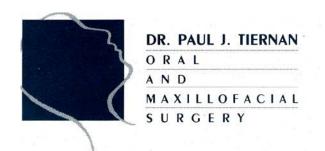
Yes No Yes No Yes No Yes No Yes No Yes No Yes No

WOMEN: Are you pregnant?

Are you practicing birth control?

Yes No 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: _		



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 ma at the email address below. I am aware that the parties might be able to read unencrypted em dental practice any updates to my email address. electronic communications by calling 707-546-47	ere is some level of risk that third ails. I am responsible for providing the I can withdraw my consent to
Email address (PLEASE PRINT CLEARLY)	
Release of Records	
I give the office of Dr. Tiernan permission to conta my treatment and to share my treatment records release is valid for a period of two years from the	in regards to ongoing treatment. This
Signed	Date
Permission to Share Information with persons	s other than dentist/physician:
I give the office of Dr. Paul Tiernan to share infortered treatment and financial responsibilities with the fo	
Signed	Date

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