Leslie Jacobs, D.D.S.

Today's Date: _____

Pediatric and Adolescent Dentistry
113 Rue Fontaine
Lafayette, La 70508

* When filling out paperwork, please make sure to fill out everything including the highlighted sections *

I. Patient Information

Name (last) _____ (first) _____ (middle) _____
Sex: Male or Female (circle one) Preferred Name: _____
Address (street) _____ (city) _____ (state) ____ (zip) _____
Phone # _____ Birthday _____ Social Security # _____
Names and ages of other children in family _____
Whom may we thank for telling you about our office _____

II. Family Information

Father _____ Mother _____
Address _____ Address _____
_____ _____
Home Phone # _____ Home Phone # _____
Cell # _____ Cell # _____
Work Phone #_____ Work Phone #_____
Employer_____ Employer _____
Social Security #_____ Social Security #_____
DOB: _____ DOB: _____
Email Address_____ Email Address_____
Marital Status: Married, Single, Widowed, Divorced (circle one) Marital Status: Married, Single, Widowed, Divorced (circle one)

III. Emergency Information

Name of nearest relative not living with you_____
Address_____ Phone #_____ Relationship_____

IV. Reason for Today's Appointment

Check up and Cleaning___ Exam Only___ Evaluate Crowding__ Toothache__ 2nd Opinion___

VI. Dental History

Is this the child's first visit to a dentist? Yes or No (circle one)
Date of child's last dental visit?_____ Dentist? _____
Has your child had any bad medical, dental or hospital experiences?_____
Please Explain: _____
Have there been any injuries to the teeth, such as falls, blows, chips, etc.? _____
Please Explain: _____

VII. Medical History

Child's Physician _____ Phone # __ _____
Has your child ever had any of the following conditions? (circle yes or no)

Allergies to any foods	**yes**	**no**	**list**_____
Allergies to any medicines	**yes**	**no**	**list**_____
Allergies to Latex	**yes**	**no**	**list**_____
Asthma	**yes**	**no**	**list**_____

*How often do attacks occur? _____
*What medicines are taken? _____

Bleeding disorders	**yes**	**no**	**Diabetes**	**yes**	**no**
Anemia	**yes**	**no**	**Kidney Problems**	**yes**	**no**
HIV +/AIDS	**yes**	**no**	**Liver Problems**	**yes**	**no**
Fainting	**yes**	**no**	**Heart Murmur**	**yes**	**no**
Hepatitis	**yes**	**no**	**Heart Abnormalities**	**yes**	**no**

History of Abuse	**yes**	**no**		**Rheumatic Fever**	**yes**	**no**
Sickle Cell Anemia	**yes**	**no**		**Special Needs**	**yes**	**no**
Fainting	**yes**	**no**		**Emotional Disturbance**	**yes**	**no**
Diabetes	**yes**	**no**		**Other** _____		
Epilepsy/ Seizures	**yes**	**no**				

What type of seizure? _____ How long do they occur? _____
How long do they last? _____ Medications Taken? _____

List surgeries and dates _____
_____
Is your child taking any medications now? yes no
*Please List: _____
Is your child under medical care at the present time for any other condition? yes no
*Please List: _____
Is there any other information about your child that you think would be of value to us for providing his/her dental care? _____
_____

CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

State law requires us to obtain your consent for dental treatment. Please free to ask us any questions you may have in regards to your child's treatment.

Examination, Prophylaxis, Fluoride, X-Rays, Dental Restorations, Extractions, Sealants, Electrosurgery, N2O, Lidocaine, Sedation

ALTERNATIVES TO THE RECOMMENDED DENTAL TREATMENT:

Any alternatives to the recommended treatment, including no treatment, have been explained to me as have the advantages and disadvantages of each.

RISK ASSOCIATED WITH THE RECOMMENDED DENTAL TREATMENT:

I understand that dentistry is not an exact science and complications may occur despite our best efforts. A partial listing of the risks known to be associated with the dental treatment and the anesthetic are:

infection, bleeding, failure of wound to heal, injuries to adjacent teeth and/or mouth, and/or face, fracture of mandible(lower jaw) or maxilla(upper jaw), opening between mouth and sinus or mouth and nose, tooth or fragment in maxillary sinus, incomplete removal of tooth, dry socket, loss of teeth, loss of bone, slough(unanticipated loss of hard and/or soft tissue), injury to adjacent structures, instrument breakage, breakage of root(s) and retained root fragments, swallowing and/or aspiration of objects, allergic reaction to drugs, trismus(jaw pain or difficulty opening mouth), failure of treatment to accomplish its purpose, bacterial endocarditis, additional oral surgery, hospitalization and/or further treatment may be required in the event of any complication(s).

State Law requires that I specifically advise you that although occurring, the dental treatment or anesthetic may result in: death, brain damage, quadriplegia, paraplegia, loss of organ(s), loss of function of an organ, loss of function of face, arm(s), or leg(s) and disfiguring scars.

ACKNOWLEDGEMENT

I acknowledge that I have read this consent from in its entirety (or that it has been read to me) and I understand the information. I understand the information contained in it, including all of the technical terms, about which I have asked if unsure. I have been given an adequate opportunity to ask whatever questions I had about the treatment. All of the questions about the treatment have been answered in a satisfactory manner.

I understand the success of this treatment and the avoidance of treatment complications depends to an extent upon my complying with the oral hygiene and dietary restrictions that have been explained to me, my following the instructions given to me, and keeping the appointments for treatment or follow-up visits scheduled or recommended. I also understand that I am to notify the dentist immediately of any suspected complication(s). I understand that further treatment may be needed if unanticipated complications occur.

I hereby authorize and direct Dr. Jacobs and/or associates or assistants of her choice, to perform the diagnostic, surgical, or dental procedures, including any necessary or advisable anesthetic.

Name (print) _____ Date _____
Name (signature) _____ Relation to patient_____