



Dr. Jason Burkett and Associates
 4336 North McColl Road
 (956) 686-5577

Consent for Dental Treatment

You have the right as a patient or as a parent to be informed about your child's condition and the recommended dental, surgical, and/or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure or have it preformed on your child. This is simply an effort to make you better informed so you may give or withhold your consent (agreement) to treatment.

I, _____ (self/parent legal guardian)
 voluntarily request Jason Burkett, D.D.S./Hien T. Ngo, D.D.S as my dentist, to treat
 _____ (self or child).

I understand the dental, surgical, and/or diagnostic procedures and I voluntarily agree with these procedures as presented in a treatment plan. I understand that this treatment plan is valid for 6-months and if not started within 6-months, a new treatment plan must be prepared for my approval.

Just as there is a possibility of loss or injury in continuing the present condition without treatment, there is also a possibility of loss or injury related to the performance of the dental, surgical, and/or diagnostic procedures planned for me or my child. In the event any dental treatment is required I will be notified. I realize that with any dental, surgical, and/or diagnostic procedures there is a risk of infection, bleeding, and allergic reaction. Problems may result from the use of Nitrous Oxide and any local anesthetic including mild discomfort, irritation to the surrounding tissues, respiratory problems, drug reaction and paralysis. I agree to the use of local anesthesia and Nitrous Oxide as necessary for the relief and protection from pain during the planned procedures.

I have been given an opportunity to ask questions about me or my child's dental condition, the procedures to be used, the risks involved, behavior management techniques including passive, restraint, propose board and moth props, choice of other treatment plans alternatives to Nitrous Oxide sedation and local anesthesia, risks of non-treatment, and I have sufficient information to give this informed consent.

I certify that this form has been fully explained to me, that I have read this form or have had it read to me and that I understand its contents.

| | | |
|---------------------------------------|--------------|------|
| Signature of Parent/Responsible Party | Relationship | Date |
| Doctor's Signature | Witness | |



Dr. Jason Burkett and Associates
 4336 North McColl Road
 (956) 686-5577

PATIENT INFORMATION

NAME: _____ DATE: _____
LAST FIRST MIDDLE

MARRIED SINGLE MINOR MALE FEMALE SOCIAL SECURITY NUMBER: _____ - _____ - _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

BIRTHDATE: _____ / _____ / _____

HOME TELEPHONE: (____) _____ WORK TELEPHONE: (____) _____

CELL PHONE: (____) _____ EMAIL: _____ @ _____ . _____

NAME OF EMPLOYER: _____ ADDRESS: _____

IF FULL TIME STUDENT, SCHOOL NAME: _____ GRADE: _____

PERSON RESPONSIBLE FOR ACCOUNT – *please check one:* PATIENT GUARDIAN SPOUSE FATHER MOTHER

INSURANCE INFORMATION

Minor Child – *May need to complete both blocks for parent information*
Adults – *Complete primary insured*
Dual Coverage? *Also complete secondary insured*

PRIMARY INSURED *if no insurance – complete for responsible party*

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME TELEPHONE: (____) _____ WORK TELEPHONE: (____) _____

CELL PHONE: (____) _____ EMAIL: _____ @ _____ . _____

BIRTHDATE: _____ / _____ / _____ RELATIONSHIP TO PATIENT: _____

EMPLOYER: _____ DENTAL INSURANCE CO.: _____

SOCIAL SECURITY NUMBER: _____ - _____ - _____ SUBSCRIBER NO. _____ GROUP NO. _____

SECONDARY INSURED

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME TELEPHONE: (____) _____ WORK TELEPHONE: (____) _____

CELL PHONE: (____) _____ EMAIL: _____ @ _____ . _____

BIRTHDATE: _____ / _____ / _____ RELATIONSHIP TO PATIENT: _____

EMPLOYER: _____ DENTAL INSURANCE CO.: _____

SOCIAL SECURITY NUMBER: _____ - _____ - _____ SUBSCRIBER NO. _____ GROUP NO. _____



Dr. Jason Burkett and Associates
 4336 North McColl Road
 (956) 686-5577

PATIENT NAME: _____

DATE: _____

Primary reason for this dental appointment: Examination Emergency Consultation

DENTAL HISTORY

Do you have a specific dental problem? Describe: _____ *Please Circle*
 Yes No
 Do you have dental examinations on a routine basis? Last visit: _____ Yes No
 Do you think you have active decay or gum disease? _____ Yes No
 Do you brush and floss on a routine basis? _____ Yes No
 Do your gums ever bleed? Discuss: _____ Yes No
 Do you like your smile? Why? _____ Yes No
 Does food catch between your teeth? Any loose teeth? _____ Yes No
 Do you want to keep your remaining teeth? _____ Yes No
 Do you ever have clicking, popping, or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
 Have your past experiences in a dental office always been positive? _____ Yes No
 Do you smoke or chew? Any sores or growths in your mouth? Discuss: _____ Yes No
 Name of previous dentist? (optional): _____
 Date of last full mouth x-rays (16 small films or panoramic): _____

MEDICAL HISTORY

Are you under a physician's care now? Yes No
 Why? _____
 Who? _____
 Phone: _____
 Have you ever been hospitalized or had a major operation? Discuss: _____ Yes No
 Have you ever had a serious injury to your head or neck? Discuss: _____ Yes No
 Are you taking any medications, aspirin, vitamins, herbals, pills, or drugs? Yes No
 What? _____
 Are you on a special diet?
 Discuss: _____ Yes No
 Are you allergic to any medications or substances? Yes No
Please check box below
 Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Milk
 Other _____
Women - Please check
 Pregnant/trying to get pregnant Yes No
 Nursing Yes No
 Taking oral contraceptives Yes No
 Discuss: _____

Do you now have or have you ever had any of the following? Do you take any of these medications? *Please check appropriate boxes.*
 If yes to any of the starred conditions, please call prior to your appointment. Pre-medication or changes in medication may be required.

| | | | | | | | |
|-----------------------------|--------------------------|------------------------------|--------------------------|------------------------------|--------------------------|-------------------------|--------------------------|
| Heart Disease/Surgery* | <input type="checkbox"/> | Recent Blood Transfusion | <input type="checkbox"/> | Frequent Diarrhea | <input type="checkbox"/> | Tattoos/Body Piercing | <input type="checkbox"/> |
| Heart Murmur or Defect | <input type="checkbox"/> | Swelling of Limbs | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | Cold Sores | <input type="checkbox"/> |
| Irregular Heart Beat | <input type="checkbox"/> | Lung Disease | <input type="checkbox"/> | Excessive Thirst | <input type="checkbox"/> | Fever Blisters | <input type="checkbox"/> |
| Angina/Chest Pain | <input type="checkbox"/> | Breathing Problem | <input type="checkbox"/> | Hypoglycemia | <input type="checkbox"/> | Herpes | <input type="checkbox"/> |
| Heart Attack/Failure | <input type="checkbox"/> | Shortness of Breath | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | Stroke | <input type="checkbox"/> |
| Congenital Heart Disorder* | <input type="checkbox"/> | Frequent Cough | <input type="checkbox"/> | Hepatitis A (Infectious) | <input type="checkbox"/> | Convulsions | <input type="checkbox"/> |
| Mitral Valve Prolapse* | <input type="checkbox"/> | Hay Fever | <input type="checkbox"/> | Hepatitis B or C | <input type="checkbox"/> | Epilepsy or Seizures | <input type="checkbox"/> |
| Scarlet Fever | <input type="checkbox"/> | Sinus Trouble | <input type="checkbox"/> | Protease Inhibitor | <input type="checkbox"/> | Fainting or Dizziness | <input type="checkbox"/> |
| Rheumatic Fever* | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | Night Sweats | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> |
| Artificial Heart Valve* | <input type="checkbox"/> | Bloody Sputum | <input type="checkbox"/> | Yellow Jaundice | <input type="checkbox"/> | Tumors or Growths | <input type="checkbox"/> |
| Heart Pace Maker* | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | Kidney Problems | <input type="checkbox"/> | Nervousness | <input type="checkbox"/> |
| Pulmonary Shunt* | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | Renal Dialysis | <input type="checkbox"/> | Psychiatric Care | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | Thyroid Disease | <input type="checkbox"/> | Alzheimer's Disease | <input type="checkbox"/> |
| Low Blood Pressure | <input type="checkbox"/> | X-Ray Treatments (Radiation) | <input type="checkbox"/> | Parathyroid Disease | <input type="checkbox"/> | Allergies (Medicines) | <input type="checkbox"/> |
| Bacterial Endocarditis* | <input type="checkbox"/> | Chemotherapy | <input type="checkbox"/> | Arthritis/Gout | <input type="checkbox"/> | Allergies (Pollen/Dust) | <input type="checkbox"/> |
| Unexplained Fever | <input type="checkbox"/> | Osteoporosis | <input type="checkbox"/> | Rheumatism | <input type="checkbox"/> | Hives or Rash | <input type="checkbox"/> |
| Bruise Easily/Blood Disease | <input type="checkbox"/> | Bisphosphonates | <input type="checkbox"/> | Pain in Jaw Joints | <input type="checkbox"/> | Need Pre-medication? | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | Osteonecrosis of Jaw | <input type="checkbox"/> | Cortisone Medicine | <input type="checkbox"/> | Ever taken Fen-Phen?* | <input type="checkbox"/> |
| Coronary Stent* | <input type="checkbox"/> | Aradia I.V. Reclast I.V | <input type="checkbox"/> | Artificial Joint* | <input type="checkbox"/> | Cochlear Implants? | <input type="checkbox"/> |
| Excessive Bleeding | <input type="checkbox"/> | Zomesta I.V. | <input type="checkbox"/> | Sexually Transmitted Disease | <input type="checkbox"/> | | |
| Sickle Cell Disease | <input type="checkbox"/> | Fosamax, Actonel, Boniva | <input type="checkbox"/> | AIDS | <input type="checkbox"/> | | |
| Hemophilia | <input type="checkbox"/> | Stomach/Intestinal Disease | <input type="checkbox"/> | HIV Positive | <input type="checkbox"/> | | |
| Methemoglobinemia | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> | Genital Herpes | <input type="checkbox"/> | | |
| Leukemia | <input type="checkbox"/> | Recent Weight Loss | <input type="checkbox"/> | Drug Addiction/Alcoholism | <input type="checkbox"/> | | |

Have you ever had any other serious illness not checked above? Yes No
 Discuss: _____

Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____
 PATIENT SIGNATURE (PARENT OR GUARDIAN) Date

Reviewed by Doctor: _____ Date: _____ BP _____ Pulse _____

History Review and Significant Findings: _____

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

| Date | EXCEPTIONS | PATIENT'S SIGNATURE | BP | PULSE | REVIEWED BY |
|-------|------------|-------------------------------|-------|-------|-------------|
| _____ | _____ | NONE <input type="checkbox"/> | _____ | _____ | DR. _____ |
| _____ | _____ | NONE <input type="checkbox"/> | _____ | _____ | DR. _____ |
| _____ | _____ | NONE <input type="checkbox"/> | _____ | _____ | DR. _____ |
| _____ | _____ | NONE <input type="checkbox"/> | _____ | _____ | DR. _____ |
| _____ | _____ | NONE <input type="checkbox"/> | _____ | _____ | DR. _____ |
| _____ | _____ | NONE <input type="checkbox"/> | _____ | _____ | DR. _____ |