Total Health Hygiene, PLLC

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Informed Consent to Perform Dental Hygiene Therapy

I _____, (resident name) request and authorize dental hygiene care be performed as needed from Total Health Hygiene, PLLC in order to maintain a healthy oral condition.

A. Dental Hygiene Therapy Offered:

I understand the dental hygiene care offered by Total Health Hygiene, PLLC to maintain a healthy oral condition includes a first appointment consisting of an oral screening, including intra/extra oral evaluation, tooth charting, evaluation of bone and gum tissue, oral hygiene status, an assess and review of medications and medical records, a physician consult, blood pressure and pulse monitoring, dental hygiene diagnosis, a treatment plan recommendation and referral. [_____]Initial

I understand treatment stemming from this first appointment could include those services outlined in Attachment A appended hereto. These include, but are not limited to: (a) an adult prophylaxis which is the removal of soft and hard deposits from teeth with no or minimal gum disease; (b) periodontal debridement involves scaling to remove supra and subgingival calcified deposits, remove biofilm, debris, and bacteria from the root surface of teeth where bone loss is present in the mouth; (c) periodontal debridement quadrant scale if the bone supporting teeth and gums recess down from their healthy level and calculus is present. More time is involved to complete debridement of crown and root surface of teeth. Tooth mobility is an indication of severe bone loss; (d) periodontal maintenance occurs after periodontal treatment has been completed. It is recommended these cleanings occur more frequently 3-4 times a year to maintain optimal oral health; (e) fluoride application to enhance the remineralization of hard tooth surfaces; (f) partials/dentures cleaning to remove debris that may cause infection to the surrounding tissues or cause improper fitting leading to discomfort; (g) and other more intensive treatment services if applicable to the patient. [_____]Initial

I understand that Total Health Hygiene, PLLC only offers preventive dental hygiene treatment. It is important to visit a dentist annually for dental exam. I understand that all dental hygiene services are provided by a registered dental hygienist. [_____] Initial

I am aware of the benefits of dental hygiene treatment and understand the results may vary. Daily removal of food and plaque is crucial to maintain optimal oral health. Daily brushing, using aides recommended by dental hygienist such as proxy brushes, floss holders, stimudents, and electric tooth brushes can help promote healing and prevent growth of biofilm and bacterial debris. [_____] Initial

B. Risks of Treatment:

I understand the risks associated with dental hygiene treatment can include, but not limited to, bleeding and tenderness around the areas affected by the removal of bacteria build up caused from plaque and calculus present in the mouth. In rare cases a periodontal abscess could occur due to bacteria lodged into the tissue. If any swelling, redness, pain, or fever occurs contact your physician immediately. [_____]Initial

I understand that alterations in medication maybe necessary in order to have dental hygiene care. This is done by your physician's recommendations based on individual health condition. According to the American Heart Association taking antibiotics prior to dental hygiene appointments may prevent infections from bacterium in the mouth entering the bloodstream. Your physician may alter blood thinner dosage to reduce excessive bleeding during and after treatment. Please discuss any concerns with medications with your physician or dental hygienist. [_____] Initial

I understand that fluoride maybe applied to aide in reducing sensitivity and/or sensitive toothpaste maybe recommended for use after the cleaning is performed to help reduce symptoms of sensitivity. Additionally, an oral mouth rinse maybe recommended following treatment to aide in the healing process. I also understand that every effort will be made to keep the client safe from unintentional movement during treatment and that no treatment will be completed if the movements interfere with safe delivery of dental hygiene treatment. [_____]Initial

C. Consequences of Non-Treatment:

I understand the consequence of non-treatment will result in a progression of infection which includes, but are not limited to, continued destruction of gum tissue and bone structure as well as gum infections that can affect the overall health of people leading to pain, swelling, and fever. I also understand that in some cases oral inflammation can spread to other parts of the body and it has been associated with cardiovascular disease relating to heart attack and stroke[1]. I also understand that infections from broken or missing teeth can lead to insufficient nutritional intake and contribute to difficulty speaking, chewing adequately, bad breath, poor appearance, and potential for social isolation.
[_____] Initial

D. Payment for Services.

I understand that I am responsible for payment of all dental hygiene services provided as detailed in the Fee Schedule appended hereto as Attachment A.
[_____] Initial

I understand that if I have <u>private dental insurance</u> I <u>*maybe*</u> eligible for reimbursement. I agree that fees for services will be paid, upon receipt of statement, to Total Health Hygiene, PLLC by the responsible party indicated below.
I have contacted my insurance company to determine:

- If the policy will pay for services directly provide by a dental hygienist.
- Which services my policy will pay for.
- If prior authorization is needed by the insurance company for dental hygiene services.

Total Health Hygiene, PLLC will send an insurance claim and invoice statement to the responsible party, to then be completed, signed and mailed by the responsible party to the insurance company for reimbursement. [_____] Initial

[1] Understanding the relationship between cardiovascular disease, oral inflammation, and dental hygiene. *Journal of Practical Hygiene*. Vol 16. Number 4.May 2007.
2. Kim, J., & Amar, S. (2006). Periodontal disease and systemic conditions: a bidirectional relationship. *Odontology / the Society of the Nippon Dental University*, *94*(1), 10–21. http://doi.org/10.1007/s10266-006-0060-6

Please Initial and Sign then Return This Form

Resident's Printed Name_____DOB_____

Signature of Responsible Party_____

Address _____

City _____State/zip_____

Telephone _____Date _____

Email_____

I would like a consultation prior to treatment rendered. I agree to pay a consultation fee of $40/hour to discuss appropriate treatment. [_____]Initial

Health History Form

American Dental Association
www.ada.org

E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: (Last First Middle) | Home Phone: *Include area code* ( ) | Business/Cell Phone: *Include area code* ( )

Address: (Mailing address) | City: | State: | Zip:

Occupation: | Height: | Weight: | Date of birth: | Sex: M F

SS# or Patient ID: | Emergency Contact: | Relationship: | Home Phone: ( ) | Cell Phone: ( ) *Include area codes*

If you are completing this form for another person, what is your relationship to that person?

Your Name | Relationship

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	**Yes**	**No**	**DK**
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	**No**	**DK**
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	**No**	**DK**
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	**No**	**DK**
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

_____

_____

_____

_____

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications?_____			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink In a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Metals	☐	☐	☐
Latex (rubber)	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food	☐	☐	☐
Other	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease.	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date:_____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐

	Yes	No	DK
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify:_____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify:_____			
Recurrent Infections	☐	☐	☐
Type of infection:_____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: | Phone:

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: | Date:

FOR COMPLETION BY DENTIST

Comments:_____

Physician Release Form

Total Health Hygiene, PLLC
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Total Health Hygiene, PLLC provides preventive dental hygiene care in alternative health care settings by a registered dental hygienist in accordance with RCW 18.29.056. We would like to provide your patient _____ our dental hygiene services as needed. Please mark and sign in the appropriate area to release your patient for treatment.

[ ] I release the patient to be seen by *Total Health Hygiene, PLLC* for dental hygiene services. No additional medications are needed for this patient to be seen at this time.

[ ] I require antibiotic prophylaxis with dental procedures. Attached is the prescription for antibiotic prophylaxis.

[ ] I require alteration of daily medications prior to dental hygiene services.

[ ] I require a sedative to reduce stress during and after dental treatment.

[ ] I authorize a sedative_____

[ ] I will not authorize allow for preventive dental hygiene procedures at this time.

Notes:

Patients INR number (if pertains to client) _____

_____

Physician Signature Date

_____

Print Name