ELITE DENTAL ASSOCIATES

Dallas Uptown – (214) 220-2424

1. NEW PATIENT APPOINTMENT

I understand that I am a new patient at Elite Dental Associates. The following procedure will be performed at my first visit:
Complete New Patient Oral/Perio Evaluation_X_ Oral Cancer Screening_X_ Periodontal Screening_X_. Prophy/Cleaning or Full Mouth Debridement (Periodontal Patients)_X_ All Necessary X-Rays/Radiograph/Photography of Treatment_X_.

Initial Blood Pressure _____ Pulse _____

(Patient Initial_____) (Staff _____)

*Please note that we believe in the benefit of in-office concentrated fluoride treatment after preventive care. The **American Dental Association** has continuously endorsed the use of fluoride-containing products as safe and effective measures for preventing tooth decay but vast majority of insurance companies do **NOT** cover this expense for adults. We believe the benefits of fluoride outweigh the minimal cost of **$24** for this application. You, as a patient, have the right to decide on this benefit. Please initial below on your acceptance or decline of this highly beneficial fluoride treatment. If you are parent or guardian of a patient under the age of 18, please initial below on their behalf.*

(Acceptance Initial_____) (Decline Initial_____)

2. DRUGS AND MEDICATIONS

I understand that antibiotics, analgesics, nitrous oxide, antibiotic pre-med, oral conscious sedation meds and other medications administered by our doctors can cause allergic reactions causing redness, bruising, and swelling of tissue in the mouth and/or on the facial tissue, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction) which may require hospitalization ***at the cost to the patient***; I also understand that our doctors will base his professional administration of drugs & medication based on the medical history and drug allergy provided by me on the patient information form. I absolve all members/employees of Elite Dental Associates of all responsibility if medication is not taken as prescribed. I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more until fully recovered from the effects of the anesthesia or drugs prescribed for my care.

OPTIONAL: You may choose to add NITROUS OXIDE ANALGESIA as a *supplement* to local anesthesia. The cost for this procedure is *$67 per session or dental visit*. Use of nitrous oxide requires that we obtain your consent.

NITROUS OXIDE is also known as "laughing gas." You will be relaxed and somewhat less aware of your surroundings, as well as less responsive to minor discomfort, and you may or may not recall much of the procedure. Nitrous oxide is breathed through a nasal mask and, after a state of relaxation is reached, local anesthesia is administered. Nitrous oxide has few lasting effects, and you usually may drive safely after a fairly brief recovery time. However, for safety precautions, its use does require some preparation on your part. Thus, it is important that you read and understand the information below and that you prepare by following the instructions carefully. If you are unclear about anything, please ask your doctor.

1. Recovery time from nitrous oxide is usually very short, but may be prolonged, requiring you to remain in the office for some time after surgery. Rarely, you may be unable to drive home alone. Thus, it is best to arrange for a responsible friend or family member to be "on call" for such a possibility.
2. Although not usually required, it may be best to have a responsible adult accompany you to drive you home.
3. You may have a light meal a few hours prior to surgery.
4. Plan to rest for the remainder of the day.

I understand that the use of nitrous oxide, although usually safe and without lasting consequences, may effect me differently. I am prepared to deal with any undesirable side effects of nitrous oxide and understand that those possibilities listed above, as well as others not considered, may occur. I agree to the use of Nitrous Oxide analgesia ("Laughing Gas") to supplement the local anesthesia planned for my procedure.

Female Patients: It has also been explained to me, and I understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, I understand that I will need to use some additional form of birth control for one complete cycle of birth control pills after the course of antibiotics or other medications is completed.

(Patient Initial_____) (Staff_____)

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change, add or delete procedures because of the conditions found while working on the teeth that were not able to be discovered during our oral and x-ray examination; the most common being root canal therapy following routine restorative procedures (i.e. Fillings, crowns, etc). I give my permission and trust to the treating doctor to make any/all changes and additions as necessary for the best interest of my dental health. Fees for additional procedure will apply and I will be responsible for that additional cost.
Note: X-Rays may need to taken before, during and/or after treatment per your insurance coverage or in-office document; these x-rays are required by the insurance companies to obtain your coverage; most insurance companies cover this additional cost but if your insurance does not cover this cost, you are responsible for the fees involved in obtaining these required x-rays.

(Patient Initial_____) (Staff_____)

Patient/GuardianSignature_____Date:_____

Witness/Staff_____Date:_____