DentalEd Inc.

UBC DENTISTRY
CONTINUING DENTAL EDUCATION

For Office Use Only

Patient Number: _____ Initial Examination Date: _____

Treatment Date 1: _____ Treatment Date 2:_____

Assigned Dentist: _____ Waiting List patient: Yes / No

VOLUNTEER INFORMATION PACKAGE

SAFE AND EFFECTIVE MODERATE IV SEDATION PROGRAM

PLEASE COMPLETE THIS FORM

Thank you for your interest in participating as a volunteer patient. You have an opportunity to participate in a continuing educational program delivered by UBC Faculty of Dentistry and DentalEd Inc. The dentists who will be providing intravenous sedation and basic dentistry to you are fully licensed and experienced. They are doing extra training in IV sedation, and will be overseen at all times by experienced faculty made up of physicians, nurses, and dentists.

Each dentist in the program must undertake 21 sedation cases. Each case must only last for approximately one hour. For this reason the procedures must be limited to basic dentistry: fillings, cleanings, and tooth extractions.

WHAT WE WILL PROVIDE FOR YOU

As a volunteer you will not be charged any fees for participating in the course as a patient.

You will receive:

- An initial dental examination and X-rays so that we can form a dental care plan for you. Dental sessions will be then organized for you depending on what is identified during the initial exam. If your teeth are in good health and no specific dental treatment is needed then you can still have a deep dental cleaning done under sedation.
- If any further treatment relating to the dental procedures is necessary, we will assist you in arranging follow-up care.
- After the initial exam, your procedure will be scheduled on one or more of the clinical treatment dates available. You may attend on more than one day if needed

DentalEd Inc.

UBC DENTISTRY
CONTINUING DENTAL EDUCATION

WHAT STEPS WE NEED YOU TO COMPLETE

1. Fill out the included Information/medical questionnaire.
2. Select a preferred date for your dental treatment day under sedation.
3. Attend as booked and have treatments completed

TREATMENT DATES

The following dates are available for dental appointments for your sedation and treatment. Please choose your 1st, 2nd, and 3rd choices for the following dates. List morning or afternoon as your best time of day choice

A. January 10 _____ Best time of day _____
B. January 11 _____ Best time of day _____
C. January 12 _____ Best time of day _____
D. January 13 _____ Best time of day _____

Comments_____

_____

PATIENT MEDICAL HISTORY

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. **Please fill in the entire form**

Date: _____

Name: _____ Male: ☐ Female: ☐

Date of Birth: Y_____/M_____/D _____ Age: _____

Email address: _____

Home Address: _____City: _____

Postal Code: _____ Phone: Res _____ Cellular_____

Person to notify in case of emergency: _____Relationship:_____Phone:_____

If applicable, name of parent or legally authorized representative: _____

Family Doctor Name: _____ Phone: _____

Medical Specialist Name (if applicable):_____ Phone: _____

Height: _____ Weight: _____

DentalEd Inc.

UBC DENTISTRY
CONTINUING DENTAL EDUCATION

MEDICAL HISTORY QUESTIONNAIRE

1. Have you ever had minimal or moderate sedation? Yes / No If yes, when? _____

2. Any complications? Yes / No_____

3. Any history of sedation/anaesthetic complications in your family? Yes / No_____

4. Are you being treated for any medical condition at the present or within the past year? Yes / No

If yes, please explain:

_____

_____

5. When was your last medical check-up? _____

6. Has there been any change in your general health in the past year? Yes / No If yes, please explain.

_____

_____

7. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? Yes / No

If yes, please list:

_____

_____

8. Do you have any allergies? Yes / No If yes, please list using the categories below:
   a. Medications: _____
   b. latex/rubber products: _____
   c. other (e.g., hay fever, foods): _____

9. Have you ever had a peculiar or adverse reaction to any medicines or injections? Yes / No

If yes, please explain: _____

_____

10. Do you have or have you ever had asthma? Yes / No
11. Do you have or have you ever had any heart or blood pressure problems? Yes / No
    If yes please explain:

    _____

    _____

    _____

12. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (e.g. infective endocarditis), a heart condition from birth (e.g. congenital heart disease) or a heart transplant?
    Yes / No If yes, please explain below:

    _____

    _____
13. Do you have a prosthetic or artificial joint? Yes / No
14. Do you have any conditions or therapies that could affect your immune system (e.g., leukemia, AIDS, HIV infection, radiotherapy, chemotherapy) Yes / No
    If yes, please explain:

    _____

    _____
15. Have you ever had hepatitis, jaundice or liver disease? Yes / No If yes, please explain:_____

_____

16. Do you have a bleeding problem or bleeding disorder? Yes / No If yes, please explain:_____

_____

17. Have you ever been hospitalized for any illnesses or operations? Yes / No
    If yes, please explain: _____

_____

18. Do you have or have you ever had any of the following? Please circle

Pacemaker	lung disease	rheumatic fever
cancer	arthritis	chest pain, angina
heart attack	stroke	shortness of breath
mitral valve prolapse	heart murmur	tuberculosis
steroid therapy	diabetes	stomach ulcers
drug/alcohol dependency	seizures (epilepsy)	thyroid disease
kidney disease	osteoporosis medications (e.g. Fosamax, Actonel)	

19. Are there any conditions or diseases not listed above that you have or ever had? Yes / No

If yes, please explain: _____

20. Are there any diseases or medical problems that run in your family? (e.g., diabetes, cancer, or heart disease) Yes / No If yes, please explain: _____
21. Do you smoke or chew tobacco products? Yes/No
22. Do you have a history of snoring/sleep apnea? Y/N If so do you use a home CPAP machine? Y/N
23. Are you anxious during dental treatment? Yes / No

    If yes, please circle your rating (one is low, five is high) 1 2 3 4 5
24. Have you received treatment for alcohol or drug use? Yes / No
25. Do you use narcotics or sedatives on a regular basis Yes/No
26. Is there any problem or medical condition that you wish to discuss in private only? Yes / No
27. WOMEN ONLY: Are you pregnant or suspect you might be? Yes/No Anticipated delivery date? _____
28. WOMEN ONLY: Are you breast-feeding? Yes/No
29. WOMEN ONLY: Are you taking any birth control pills? Yes/No

NOTE: IT IS IMPORTANT THAT ANY CHANGES IN YOUR HEALTH STATUS BE REPORTED TO OUR OFFICE.

I, the undersigned, certify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I also consent to my physician being contacted if necessary to obtain information that is required for my dental care.

Signature: _____ Date: _____

Patient: _____ Parent: _____ Legally Authorized Representative: ___

DentalEd Inc.

UBC DENTISTRY
CONTINUING DENTAL EDUCATION

Office Use Only

Reviewed by Program Coordinator: Y/N Date: _____

ASA Score: _____

Request a physician consult? Yes / No

Notes:_____
_____
_____
_____
_____
_____
_____