

***Forming an intent; moving forward & following your heart; being true to yourself***

**Not CANCELLING, CHANGING OR POSTPONING YOUR DENTAL APPOINTMENT**

Form an intent in your heart to move into a healthier mouth. For people who experience a high level of fear at the mere thought of a visit to a dental office, just making the first call to schedule an appointment is a very difficult challenge. I want to congratulate you for taking that first step toward looking and feeling great about your dental health!

The next challenge will be getting to your first appointment. The fear you feel may cause you to consider calling us to cancel or postpone your initial visit. Remember the intent you formed in your heart to move towards a healthier mouth. Your companion can be a major supporter to help you follow through with that which you intended. The following are just some of the excuses that patients have thought to use that let fear stand in the way of getting what they want.

I am sick  
I can't get off work  
My boss won't let me leave work  
My child is sick  
My car is in the shop  
I have a family emergency  
I can't afford it  
I have a flat tire


We realize that all of the above reasons are part of real life but we ask that you recognize, as we do, that many times fear is stopping you.

If you need a prescription for a medication to help relieve your anxiety before your first visit, please tell us. This is a very common request. Many patients need a prescription for something to take the night before the appointment just to help them get to sleep.

I have made a commitment to my patients to do whatever it takes to make them comfortable during their visits with us. If it takes medication, "laughing gas", or sedation my team and I are here to help you.

Make a commitment to yourself now to follow through. You have already formed an intent to seek out the help that you need. We are, for many high fear dental patients, a ray of light and hope, *a window of opportunity.*

Compassionately,



Dr. Joseph Vaughan

I understand that cancelling my sedation appointment less than 48 hours in advance or failing to show up for my sedation appointment will result in a charge of \$200 consultation fee.

Patient:

Date:

# HEALTH HISTORY

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Date of last health care exam: \_\_\_\_\_ What was this exam for? \_\_\_\_\_

Are you currently receiving care? No Yes If yes, nature of care: \_\_\_\_\_

Have you ever had any serious illness, surgery or been hospitalized? (Please circle) No Yes

If yes, reason: \_\_\_\_\_

**Please list all the names and phone numbers of the physicians who are currently providing you care:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

***For the following medical conditions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.***

Blood Pressure: High Low	No	Yes	Stroke?	No	Yes
Diabetes	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Heart Disease, Angina, Heart Attack, Heart Surgery	No	Yes	Fainting or Dizzy Spells	No	Yes
Heart Stent or Pacemaker When placed?	No	Yes	Kidney Disease	No	Yes
Heart Valve (damaged/artificial) or Heart Transplant	No	Yes	Renal Dialysis	No	Yes
H.I.V. Infection/AIDS or ARC	No	Yes	Glaucoma	No	Yes
Women: Are you pregnant?	No	Yes	Cancer or Tumor?	No	Yes
Are you trying to become pregnant?	No	Yes	Radiation or Chemotherapy?	No	Yes
Asthma or other Lung Diseases	No	Yes	Psychiatric or Mental Health Therapy	No	Yes
Emphysema or COPD other Respiratory Illness	No	Yes	Joint Replacement? When placed?	No	Yes
Sleep Apnea?	No	Yes	Previous Bacterial Endocarditis	No	Yes
Liver Disease, Jaundice, or Cirrhosis	No	Yes	Allergies? Sinus Trouble?	No	Yes
Hepatitis, Any Form	No	Yes	Slow-Healing Mouth Sores	No	Yes
Arthritis, Rheumatism or other inflammatory disease	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Blood Disorders? Abnormal Bleeding from a cut?	No	Yes	Previous Biopsies	No	Yes
Congenital Heart Disease?	No	Yes	Venereal Disease	No	Yes
Thyroid Problems?	No	Yes	Other Conditions	No	Yes
Epilepsy or other neurological disease?	No	Yes	Recurrent Illnesses	No	Yes
Is there any other problem you think I should know about?	No	Yes			

***Are you taking any of these medications?***

Pre-medication before dental treatment?	No	Yes	Tagamet <sup>®</sup> (cimetidine) or Prilosec <sup>®</sup> (omeprazole)?	No	Yes
Antacids?	No	Yes	Cardizem <sup>®</sup> (diltiazem) or Calan, Isoptin <sup>®</sup> (Verapamil)?	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Serzone <sup>®</sup> (nefazodone)	No	Yes
Dilantin <sup>®</sup> or Tegretol <sup>®</sup>	No	Yes	Diflucan <sup>®</sup> (fluconazole) or Sporonox <sup>®</sup> (itraconazole)	No	Yes
Barbiturates (any)	No	Yes	Biaxin <sup>®</sup> (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax <sup>®</sup> , Aredia <sup>®</sup> , Zometa <sup>®</sup> , Actonel <sup>®</sup> , Boniva <sup>®</sup> , RECLAST) or PROLIA? If so, when did the treatment begin? _____ When did the treatment end? _____				No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

**Please list any medications you are currently taking, the dosages and the reason for the medication:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
7. \_\_\_\_\_
6. \_\_\_\_\_
8. \_\_\_\_\_



## Patient's Companion & Designated Driver

Please designate below the name and information requested for your companion and designated driver. He/She **MUST** be over the age of 19 and remain with you until you are fully recovered at home.

Name \_\_\_\_\_

Address \_\_\_\_\_

Home Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_

Cell Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_

May we give information to your designated driver regarding your care? Y\_\_\_\_\_ N\_\_\_\_\_

Patient Name \_\_\_\_\_ Treatment Date \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Joseph G. Vaughan, DDS

130 Cedar Knoll Dr.

Ronceverte, WV 24970

**Dr. Joseph G. Vaughan DDS**  
**After Sedation Instructions for Companion & Patient**

- 1). PATIENT CANNOT DRIVE FOR 24 HOURS AFTER TAKING SEDATION MEDICATION
- 2). DO NOT OPERATE ANY HAZARDOUS DEVICES OR DO ANY HEAVY LIFTING FOR 24 HOURS.
- 3). A RESPONSIBLE PERSON SHOULD BE WITH THE PATIENT UNTIL HE/SHE HAS FULLY RECOVERED FROM THE EFFECTS OF THE SEDATION.
- 4). PATIENT SHOULD NOT GO UP AND DOWN STAIRS UNATTENDED. LET THE PATIENT STAY ON THE GROUND FLOOR UNTIL RECOVERED.
- 5). HAVING NUTRITION AFTER SEDATION IS IMPORTANT. THE PATIENT SHOULD BEGIN EATING APPROPRIATE FOOD AS SOON AS POSSIBLE. DO NOT DELAY.
- 6). PATIENT NEEDS TO DRINK PLENTY OF FLUIDS AS SOON AS POSSIBLE AND STAY HYDRATED.
- 7). PATIENT MAY SEEM ALERT WHEN HE/SHE LEAVES. THIS MAY BE MISLEADING SO DO NOT LEAVE THE PATIENT ALONE.
- 8). ALWAYS HOLD PATIENT'S ARM WHEN WALKING.
- 9). CALL US IF YOU HAVE ANY QUESTIONS OR DIFFICULTIES. IF YOU FEEL THAT YOUR SYMPTOMS WARRANT A PHYSICIAN AND YOU ARE UNABLE TO REACH US, GO TO THE CLOSEST EMERGENCY ROOM IMMEDIATELY.
- 10). PATIENT SHOULD NOT CARRY, SLEEP NEXT TO OR BE LEFT ALONE WITH THE YOUNG CHILDREN FOR A PERIOD OF NO LESS THAN 24 HOURS AFTER THE LAST DOSAGE OF MEDICATION.
- 11). NO SEDATIVES OR STIMULANTS SHOULD BE TAKEN FOR 24 HOURS AFTER THE APPOINTMENT (INCLUDING ALCOHOL, CAFFINE OR NICOTINE)
- 12) **DRIVE DIRECTLY HOME, & CALL THE OFFICE WHEN YOU ARRIVE AT HOME AND THE PATIENT IS COMFORTABLE & SAFE.**

FOLLOWING MOST SURGICAL PROCEDURES THERE MAY OR MAY NOT BE PAIN, DEPENDING ON YOUR THRESHOLD FOR PAIN. YOU WILL BE PROVIDED WITH MEDICATION FOR DISCOMFORT THAT IS APPROPRIATE FOR YOU. IN MOST CASES, A NON-NARCOTIC PAIN REGIMEN WILL BE GIVEN CONSISTING OF **ACETAMINOPHEN (TYLENOL) AND IBUPROFEN (ADVIL)**. THESE TWO MEDICATIONS **TAKEN TOGETHER**, WILL BE AS EFFECTIVE AS A NARCOTIC WITHOUT ANY OF THE SIDE EFFECTS ASSOCIATED WITH NARCOTICS. IF A NARCOTIC HAS BEEN PRESCRIBED, FOLLOW THE DIRECTIONS CAREFULLY. IF YOU HAVE ANY QUESTIONS ABOUT THESE MEDICATIONS INTERACTING WITH OTHER MEDICATIONS YOU ARE PRESENTLY TAKING, **PLEASE CALL OUR OFFICE, YOUR PHYSICIAN AND/OR YOUR PHARMACIST.**

COMPANIONS'S SIGNATURE:

PATIENT'S SIGNATURE:

DATE:

Office (304) 645-2333

Dr.'s Cell (540) 968-6752

<p><b>MEDICATIONS: Take only when checked</b> TYLENOL (ACETAMINOPHEN)-Take two every 6 hours ADVIL (IBUPROFEN)-Take two every 6 hours VITAMIN C-one (1000mg) at every meal 3x a day Co Q 10 - 50mg 2 x a day</p>
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