FREEDOM DAY

"Giving a Day of FREE for a Lifetime of FREEDOM"

OCTOBER 11, 2018

PATIENT PACKET

Treatment LIMITED TO THE FIRST 16 VETERANS that complete the Freedom Day registration process.

Please follow the instructions below to secure an appointment for Freedom Day

INSTRUCTIONS:

1) Please complete and sign all pages that require information

2) Prior to October 11, 2018, bring completed **Patient Packet** along with **ID** and **proof of Veteran Status** to Dee for Dentist to receive a confirmed appointment time for the day of the event.

Dee for Dentist
8772 S. Maryland Parkway
Las Vegas, NV 89123

NOTE: *Completion of this patient packet does not guarantee treatment. Patients that do not receive a Confirmed Appointment Time prior to Freedom Day will not be eligible for treatment*

CONSENT TO DENTAL SCREENING
Event Date: October 11, 2018

Patient Name: _____

Patient DOB:_____ Patient Phone #: _____

Patient Address _____

_____

What is your chief complaint? _____

_____

_____

_____

I understand that this screening is only a limited means for diagnosis and I must secure the services of a dentist or dental clinic.

I understand that all the services I may/may not receive are donated as part of Freedom Day and that any services that I may/may not receive do not qualify me as a patient of record of Dee for Dentist.

I understand that following any treatment from Freedom Day, it is recommended that I seek regular and continued dental care from a dental provider or clinic.

Should I choose not to seek follow-up care from a dentist or clinic as recommended, I will not hold Dee for Dentist, Freedom Day, participating dentists and staff, or any participating vendor responsible.

_____
Patient Name

_____
Patient Signature

_____
Date

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

FREEDOM DAY PHOTO RELEASE

Event Date: October 11, 2018

I hereby grant permission to Freedom Day, Dee for Dentist, participating vendors, and organizations (collectively, the "organizations" and individually, an "organization"), to take photographs and/or digital images at the above-identified event.

I hereby authorize the organizations to use, reuse, reproduce, publish, or republish any photographs, recordings, or any other record of my participation in this event, in any medium now known or hereafter developed, alone or in conjunction with other material, without restriction as to changes or alterations, as well as to use my name, voice, likeness, and/or other indicia of identity, for editorial, educational, promotional, or advertising purposes, including without limitation in connection with the solicitation of contributions and the furtherance of the objectives of Freedom Day.

I authorize use of the images without compensation to me. All negatives, prints, digital reproductions shall be the property of the organization taking the image.

_____

Patient Name

_____

Patient Signature

_____

Date

CONSENT TO TREATMENT
Event Date: October 11, 2018

☐ ***Changes in treatment plan***

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routing restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

☐ ***Changes in treatment plan***

I understand that antibiotics, analgesics, and other medications can cause allergic reactions resulting in redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been prescribed to me for my care. I understand that failure to take medications prescribed for me in the manner in which they are prescribed may offer risks of continued or aggravated infection, pain and/or potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills.) I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell my dentist all medications I am currently taking. I have informed the Dentist of any known drug allergies.

☐ ***Dental Prophylaxis (Cleaning)***

I understand that this type of cleaning is preventive in nature and is intended for patients in the absence of periodontal disease. Removal of plaque, tartar, and most stains from the tooth structure is accomplished during this procedure. The dental prophylaxis helps to prevent periodontal disease.

☐ ***Tissue Debridement***

I understand that this type of cleaning is preventive in nature and is intended for patients with heavy tartar buildup usually in the presence of inflamed & bleeding gums. It is recommended that I seek follow up care from a dental provider or clinic for an additional dental prophylaxis or more advanced treatment due to potential periodontal disease.

☐ ***Periodontal Treatment***

I understand that this type of cleaning is for patients with newly diagnosed periodontal disease and/or patients who have areas around the teeth and gums that are in need of more extensive treatment. Periodontal disease is the loss of the supporting structures (gum and bone) around the teeth and can lead to the loss of teeth. It may negatively affect other systems of the body and the general health of an individual (i.e. diabetes, heart disease, and pre-term labor, etc.) Alternative treatments include non-surgical therapy, antibiotic/antimicrobial treatment, gum surgery, and/or removal of teeth. I understand the success of any dental treatment depends in part on my efforts to brush and floss daily, receive regular cleanings as directed, follow a healthy diet, avoid tobacco products and follow other recommendations. I understand bleeding following treatment could last for several hours. Should it persist, particularly if it is severe in nature, this office needs to be contacted to receive proper attention. I understand that periodontal disease may have an adverse effect on the long term success of dental restorations.

☐ ***Tooth extraction(s)***

I understand removing teeth does not always remove the infection, if one is present, and it may be necessary to have further treatment. I understand the risks involved in having an extraction can include but are not limited to pain, swelling, spread of infection, dry socket and fractured jaw. Loss of feeling in teeth, tongue, lips and or surrounding tissue (a.k.a. Paresthesia) that can last for an undetermined period of time is also a rare but possible risk. I understand I may need further treatment from a specialist or even hospitalization if complications arise during or following treatment, costs of which would not be associated with the initial procedure. I have been advised and understand post-operative care instructions of the extraction site. Consequences of not replacing the extracted tooth/teeth have been explained to me and I understand that it is my responsibility to follow up on additional treatment.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results.

I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.

By signing this I fully understand the above information and I consent to the proposed treatment.

_____

Patient Name

_____

Patient Signature

_____

Date

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dee for Dentist's Notice of Privacy Practices on the following pages.

Patient name _____

Patient Signature _____ Date _____

Effective date of notice: October 11, 2018

NOTICE OF PRIVACY PRACTICES

Dee for Dentist

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another dentist or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of dentists; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

INSTRUCTIONS FOLLOWING SURGERY

Extraction of teeth or other oral surgery are serious procedures. To prevent complications, unnecessary pain, discomfort, and expense, the following instructions should be followed to insure proper healing.

Keep the mouth clean: Do not rinse your mouth for at least 12 hours after surgery. The day after, begin rinsing three times daily with a solution of ½ teaspoon salt dissolved in 8 oz. of water. Do not rinse vigorously or spit at first since it may dislodge the blood clot and possibly delay healing. Continue salt water rinses for one week. Resume brushing your teeth the following day, being gentle around the surgery site. Do not use a Water Pik or AirFlosser on the surgery site.

Bleeding: Immediately after surgery, bite down on the gauze given for 30 minutes. After 30 minutes, discard gauze and do not place anything in the mouth. Oozing is to be expected. If bleeding persists, place dampened gauze over extraction site and bite down for another 30 minutes.

Swelling: Swelling is a normal response following surgery but can be partially avoided by using an ice bag for the first 2 days after surgery. Place ice pack on the side of the face over the operated site and leave on for 15 minutes and off for 15 minutes. Swelling should begin diminishing by the fourth post-operative day. Elevating your head and decreasing physical exertion for a few days is helpful. Some temperature rise is to be expected during the first 2 days after surgery. Discoloration or bruising is a normal post-operative event.

Discomfort: The most discomfort you will experience will be during the period when sensation returns to your mouth. For moderate pain, one or two Advil (ibuprofen) tablets may be taken every 4-6 hours with food. Other over-the-counter options are Tylenol or Aleve but avoid aspirin. To avoid extreme pain take pain reliever before the numbing wears off. If antibiotics are prescribed take them as directed until gone. If you are on birth control pills, be aware that some antibiotics can alter the effectiveness. Discontinue medications only in the event of a rash or other unfavorable reaction and call the office. Discomfort following oral surgery will usually disappear in a few days. Persistent and/or new pain on or after the third day is most likely a dry socket. In this case call the office for further instructions.

Diet: If you are numb for a few hours following surgery, choose "non-chew" foods such as soup, Jello, pudding, applesauce, instant breakfast, milk, ice cream, etc. Yogurt is a good choice but avoid taking it with your antibiotic. Dehydration must be guarded against when having oral surgery. Since solid food is limited the first two days it is necessary to compensate for this by increasing your fluid intake to at least five to six glasses a day. Watch for nausea and avoid taking pain medication without food. Softer foods can be eaten the day following surgery like eggs, oatmeal, cereal, mashed potatoes and pasta. Do not eat anything hard, sharp or spicy (like chips or pizza) for five days.

Your mouth: It is normal to have limited opening or soreness when you try to open your jaw. After a few days the jaw can be stretched open a few times each day. Occasionally patients will bite their tongue while they are numb, this can be avoided by only having "non-chew" foods and avoid closing completely till numbing wears off. If a hard or sharp area is felt in the extraction site it is usually the bony wall which originally supported the tooth. Leave it alone and it should heal nicely. If it continues to bother you call the office.

FOLLOW-UP CARE

For follow-up care, please contact your dentist or:

UNLV School of Dental Medicine
1700 West Charleston Ave.
Las Vegas, NV 89102
(702) 774-2698