PATIENT QUESTIONNAIRE FOR ELECTIVE DENTISTRY

Freedom of choice is an ideal we cherish in this country. A meaningful choice requires individual knowledge and access to information. If you are properly informed, you are aware of alternatives available and the consequences of your options. The United States Constitution provides for the right to meaningful discussion of any issue in a public forum. The following questions may lead to discussion of certain controversial issues but do not in any way imply a recommendation for any type of treatment protocol, referral for any type of testing or evaluation by any health care practitioner, use of any particular filling or crown materials, or the connection between any medical condition and the dental condition of your mouth. Since you do have a right to choose, the following is intended to be a way for you, the patient, to communicate your choices and therefore the kind of dental care you wish to receive.

Please circle YES or NO below:

1. YES NO It is my intention to contact my physician or health care provider to determine through testing of my choice, to what extent, if any, I have toxicity related to the dentistry in my own mouth. (Our patients have used blood testing, electrodermal testing, energy testing, kinesiology, hair analysis and many others to determine toxicity. We cannot recommend any test or evaluation.)

2. YES NO It is my intention to have my fillings removed in a specific order that I will determine and I realize my dentist can only recommend that the most decayed teeth be treated first.

3. YES NO I would like to breathe oxygen while undergoing dental treatment.

4. YES NO It is requested that appointments be scheduled on different days and treatment completed in a specified time, (such as 30 days.)

5. YES NO I will attend one patient information session to clarify any questions I may have before treatment begins.

6. YES NO Any materials used in my mouth will be determined in a discussion with my dentist. I request that my dentist only use the materials I choose from those available in this office.

7. YES NO It is my desire to follow a nutritional program and to start supplements before treatment starts and continue on a program of detoxification after treatment.

8. YES NO It is my request that the dental laser be used on my teeth where decay needs to be removed. Recent studies have shown such treatment to be safe and effective. (Use of the laser is optional and is an additional fee.)

9. YES NO If the teeth in my mouth are abscessed, I will follow this office's recommendation that these teeth be saved and restored with root canal therapy and crowns.

10. YES NO Any crowns or bridges that I feel may have amalgam under them, I am requesting removal and replacement of regardless of the clinical diagnosis, quality and useful life of said restorations.

Note: Our office may refuse to remove serviceable crowns or bridges or refer you to a prosthodontist for a second opinion.

I understand that these above choices may lead to discussion of my options in this dental office and are not recommendations by the dentist or dental staff to follow any particular path of treatment. I agree to be primarily responsible for the implementation of these choices throughout my dental care.

Patient Signature ______________________________ Date______________