

AMALGAM Progress Form

CANDIDATE IDENTIFICATION NUMBER



Candidate #

Unit #

PRETREATMENT MEDICATION (If Required)

Medication(s) (Brand/Generic Name)

Dosage/When Taken

Patient Approved for Dismissal:

CFE#

ANESTHETIC RECORD

Type(s) of Injection: Infiltration Block

Anesthetic(s)

Vasoconstrictor: None 1:50,000 1:100,000

Quantity (cc.) 1.8 cc 3.6 cc

No Anesthetic Being Administered:

Additional Anesthetic Approval

(For one carpule ONLY) EXAMINER #

Patient's Name:

Assistant's Name:

PATIENT INFORMATION

The following questions must be completed in addition to the Medical Health History Form.

- 1.) Latex Allergy: NO
- 2.) Blood Pressure: 159/94 or below
- 3.) Noted Medical Condition: NO
- 4.) Physician's Clearance: NO

PROPOSED RESTORATION (Access Surface Must be Included)

Tooth #: Surfaces:

PATIENT ACCEPTABILITY

ACCEPTABLE:

EXAMINER #

NOT ACCEPTABLE:

EXAMINER #

EXAMINER #

Reason for Rejection:

- Anesthetic Record
- Medical Health History
- Proposed Restoration
- Progress Form Incomplete

LINER OR BASE CHECK

Liner/Base Placement must be checked by CFE prior to placing final restoration.

CFE #

EXPOSURE

Carious Mechanical Recognized: Unrecognized:

(Any pulpal exposure must be checked by a CFE)

Liner/Base Placement:

Checked by Captain or Chief

Exposure Processed:

Checked by Captain or Chief

DENTAL AMALGAM TREATMENT CONSENT FORM

I, _____, authorize Candidate # _____, a dental
(Patient's Name)
examination candidate, to perform upon myself the following dental procedure(s):

- a) Patient Assessment (Medical History)
- b) Amalgam Preparation and Restoration as required for examination
- c) Composite Preparation and Restoration as required for examination
- d) Radiographs as required for examination

I understand that the candidate may not be a licensed dentist. I further understand that such procedure(s) will be performed by the candidate as part of an examination conducted to determine the qualification of the candidate for licensure. I recognize that medical information which could be pertinent to the oral health care I receive in the course of the examination may be communicated to examiners.

The nature and purpose of the procedure(s) as well as the risks and possible complications have been explained to me. My questions with regard to the procedure(s) have been answered. I acknowledge that no guarantee or warranty has been made as to the results to be obtained. I understand that only a portion of my mouth will receive dental treatment today and that further treatment for that portion and/or the remainder of my mouth may be necessary. I have been informed of the availability of services to complete any services which may require follow-up care.

I further understand that the CITA Board exam is totally separate from the School of Dentistry even though the exam takes place in the school's clinics. Payment arrangements, future treatment promises, or any other agreement that I make with my candidate is not the responsibility of the School of Dentistry. The candidate may arrange for me to be an alternate patient. If the candidate does not elect to treat me during the exam, my dental needs may be treated at the school later; however, at the School's usual and customary fees.

DATED this _____ day of _____, 20 _____.

Patient's Signature () _____
Patient's Phone Number

Patient's Address City State Zip Code

Parent or Guardian's Signature (if patient is a minor)

MEDICAL HEALTH HISTORY FORM

Patient Name: _____

Birthdate: _____ Weight: _____ Date Form Completed: _____

Blood Pressure on day of exam (right arm sitting):

INSTRUCTIONS TO THE PATIENT: Answer the following questions as completely and accurately as possible. All information is **CONFIDENTIAL**. Please circle "yes" or "no" to all questions, and write in your answers as appropriate.

- | | | |
|--|-----|----|
| 1. Are you under the care of a physician at this time?
If yes, for what condition? _____ | YES | NO |
| 2. Has a physician treated you in the past six months?
If yes, for what condition? _____ | YES | NO |
| 3. Are you allergic to any medicines, drugs, latex or other substances?
If so, please specify: _____ | YES | NO |
| 4. Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or Adipex (phentermine)?
If so, please list: _____ | YES | NO |
| 5. Do you have or have you had any of the following diseases/problems? | | |
| A. Abnormal bleeding | YES | NO |
| B. Asthma | YES | NO |
| C. Heart Condition | YES | NO |
| D. Heart Valves-Damaged or Replaced | YES | NO |
| E. Heart attack | YES | NO |
| F. Heart murmur | YES | NO |
| G. Inborn heart defects | YES | NO |
| H. Infective Endocarditis | YES | NO |
| I. Mitral valve prolapse | YES | NO |
| J. Unshielded pacemaker | YES | NO |
| U. Cancer/chemotherapy/radiation | YES | NO |
| K. Rheumatic Heart Disease | YES | NO |
| L. High blood pressure | YES | NO |
| M. Diabetes (list type) | YES | NO |
| N. Active Tuberculosis | YES | NO |
| O. Kidney/renal disease | YES | NO |
| P. Hepatitis/jaundice (list type) | YES | NO |
| Q. Epilepsy/seizures | YES | NO |
| R. Joint replacement | YES | NO |
| S. Stroke | YES | NO |
| T. Thyroid problems | YES | NO |

Please explain any YES answers: _____

6. Do you have any disease, condition, or problem not listed above that would pose a significant risk to the health or safety of yourself or others during the performance of dental procedures? YES NO If yes, please explain.

- *7. There are some drugs that interact with local anesthetics and can put you at risk. Please list any **premedication, medications, pills, or drugs** which you are currently taking-both prescription and nonprescription-especially anything you have consumed within the last 24 hours.

8. Have you ever taken drugs such as Boniva or Fosamax for Osteoporosis? YES NO If yes, please explain.

WOMEN ONLY: Are you pregnant? YES NO If yes, what is the expected due date? _____

I certify that I have read and understand the above. I acknowledge that I have answered these questions accurately and completely. I will not hold CITA responsible for any action taken or not taken because of errors I may have made when completing this form.

PATIENT SIGNATURE

DATE SIGNED

All items marked with an asterisk must be completed the DAY OF THE EXAMINATION!