Practice / stamp

Medical History and Dental Consent

Client details

Full name

Date of birth

Phone

Date

PATIENT HEALTH RECORD / CONSENT TO DENTAL TREATMENT

Important contraindications — please tell your dentist before treatment

- Bisphosphonates (risk of jaw osteonecrosis — you MUST inform us)
- Pacemaker or artificial heart valves
- Haemophilia or other clotting disorders
- Pregnancy (especially the 1st and 3rd trimester — anaesthesia given with caution)
- Allergy to lidocaine / articaine (local anaesthetics)
- Active cold sores in or around the mouth
- Anticoagulant medication
- Heart attack or stroke in the last 6 months
- Autoimmune conditions (rheumatoid arthritis, Sjögren's syndrome)

MEDICAL HISTORY — this section must be completed. Withholding information may endanger the patient's health and life.

Heart conditions (heart attack, high blood pressure, valve defects, coronary artery disease) or a heart attack/stroke in the last 6 months? ☐ Yes ☐ No

Pacemaker or artificial heart valves? ☐ Yes ☐ No

Blood disorders (anaemia, haemophilia, clotting disorders)? ☐ Yes ☐ No

Diabetes, thyroid conditions, asthma? ☐ Yes ☐ No

Infectious diseases (hepatitis B/C, HIV, tuberculosis)? ☐ Yes ☐ No

Pregnant? ☐ Yes ☐ No

If YES — which week of pregnancy?

Allergies to medication / latex / metals (please specify, or write NONE)

Anticoagulant medication? ☐ Yes ☐ No

☐ OSTEOPOROSIS / bisphosphonates — withholding this information risks jaw osteonecrosis!

Any past allergic reaction to local anaesthetic? ☐ Yes ☐ No

List of medication taken regularly

CONSENT TO TREATMENT — I give my informed consent to an examination of my mouth, the administration of local anaesthetic, X-ray diagnostics, and the proposed dental treatment plan. The dentist has fully explained the planned procedure, its possible complications, alternative treatment options and the estimated costs. All health information I have given is true.

☐ *I consent to the X-rays recommended for me. I have been informed that ionising radiation is used for diagnostic purposes, which carries minimal risk to health.*

☐ *I give my informed consent to the dental treatment and the administration of local anaesthetic*

☐ *I confirm that I have read the above information about the processing of my health data for diagnostic and treatment purposes*

Providing contact details is necessary for the smooth delivery of your treatment plan. The practice reserves the right to contact you for treatment-related and administrative purposes (Article 6(1)(b) and Article 9(2)(h) GDPR). Please note that Finnish law requires dental patient records to be kept for a markedly long period — at least 12 years after the patient's death or up to 120 years from birth if the date of death is unknown (section 23 of Act 703/2023, in force since 1 January 2024).

☐ *I agree to be contacted for marketing purposes (newsletter, preventive care campaigns, offers) — this consent is voluntary and I can withdraw it at any time*

GDPR DECLARATION — I confirm that I have read the notice explaining that the data controller for my data is _____, registered address: _____, Business ID (Y-tunnus): _____. My health data is processed for diagnostic and treatment purposes (Article 9(2)(h) GDPR). Under section 23 (Asiakasasiakirjojen säilyttäminen) of the Act on the Processing of Client Data in Social and Health Care Services (laki sosiaali- ja terveydenhuollon asiakastietojen käsittelystä, 703/2023, in force since 1 January 2024 and replacing the earlier Ministry of Social Affairs and Health regulations 94/2022 and, before that, 298/2009), dental patient records must be kept for at least 12 years after the patient's death or, if the date of death is not known, 120 years from the patient's date of birth — a rule that has applied to non-permanently-archived patient records in Finland since a national archival policy of 1 May 1999 and is now continued under the current Act, and which is materially longer than in many other countries. I have the right to access, rectify or erase my data and to lodge a complaint with the Office of the Data Protection Ombudsman (tietosuoja.fi). The right to erasure does not extend to the patient records the practice is legally required to keep.

Date

Patient signature (medical history, consent to treatment and GDPR)

Aftercare Instructions Following Extraction / Oral Surgery

AFTERCARE INSTRUCTIONS FOLLOWING EXTRACTION / SURGERY — Read and confirm each point. Not following them can lead to complications requiring a further appointment.

1. GAUZE: Bite down firmly for 30–40 minutes without spitting it out. Slight oozing for a few hours is normal. If bleeding continues for more than 1 hour — use a fresh piece of gauze and contact the practice.

- [ ] I understand the instructions for biting on the gauze and know when to contact the practice

2. EATING: Do not eat or drink for 2 hours (until the anaesthetic wears off). For 24 hours: a cold, soft diet (yoghurt, soup). Avoid hot drinks.

- [ ] I agree not to eat for 2 hours and to keep to a cold, soft diet for 24 hours after the procedure

3. STRICTLY AVOID for 24-48 hours: smoking, drinking through a straw, strenuous physical activity, rinsing the mouth. Any of these can cause dry socket — an extremely painful condition that requires a further procedure.

- [ ] I understand and agree to strictly avoid smoking, drinking through a straw and strenuous activity for at least 24 hours

4. HYGIENE: Brush your teeth as normal, avoiding the treated area. From the next day: gently rinse with salt water after eating. Avoid alcohol-based mouthwash.

- [ ] I understand the instructions for brushing my teeth and rinsing my mouth after the surgical procedure

5. MEDICATION: Take painkillers / antibiotics as prescribed by your dentist. Avoid aspirin (increases bleeding). If pain worsens after day 3 — contact the practice immediately.

- [ ] I will take medication as prescribed and will contact the practice if pain worsens after day 3

Date

Patient signature (aftercare instructions received)