Date:_________________________
Patient:____ DOB:_____________
Procedure:____
*Escort/Relation Name & Contact Info (Sedation):__________________________________

Responsibility	**Checklist**	**YES**	**NO**
CDA/Admin	Treatment plan consent (signed)		
CDA/Admin	Correct patient name/DOB/Insurance info		
CDA/Admin	Payment		
CDA	Allergies		
CDA	Medical history reviewed		
CDA	Medications reviewed		
CDA	Implanted medical devices or joint prosthetics		
CDA	Contact lenses, hearing aids, removable teeth		
CDA	Jewelry, piercings removed		
CDA	Radiographs: pre-op		
CDA	Surgical guide, impressions		
CDA	Provisional appliance, denture		
Dentist	Consult/re-consult with Dentist		
CDA/Dentist	Prescriptions printed/signed by Dentist		
CDA/Dentist	Sedation (if yes, note escort info above*)		
CDA	Consent for procedure (signed)		
CDA/Dentist	Questions/concerns addressed		
CDA	Oral rinse @ ___________hour		
Dentist	Pre-op Meds		
CDA	Sterile Technique: ______ Aseptic Technique: ______		
CDA	Treatment room, equipment ready		
CDA	Radiographs: post-op		
CDA	Post-op instructions		
CDA	Follow-up appointment		