# PATIENT INFORMATION

Patient Name: _____ Patient #: _____ Date: _____
Last First M

Address: _____
Street Apt. # City State Zip

Birthdate: ___/___/___ Telephone: Home: _____ Work: _____ Cellular/Pager: _____

Height: _____ Weight: _____ Sex: ☐ M ☐ F Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Full Time ☐ Part Time

If Student, _____
Name of School/College City State Grade

Patient's Employer: _____ Occupation: _____ SS#: _____

Business Address: _____
Street Suite # City State Zip

Spouse Name: _____ Employer: _____ Work Phone: _____

Person to contact in case of emergency: _____ Relationship: _____ Phone: _____

If you are completing this form for another person, what is your relationship to that person? _____

Whom may we thank for referring you to our office? _____

Name of Person Responsible for this Account: _____ Relationship to Patient: _____

Address (if different from above): _____
Street Apt. # City State Zip

Birthdate: ___/___/___ Telephone: Home: _____ Work: _____

SS #: _____ Driver's License #: _____

## Primary Dental Coverage Information

**If you do NOT have primary coverage, please check this box: ☐**

Name of Insured: _____ Relationship to Patient: _____ Birthdate: ___/___/___

Address (if different from above): _____ City: _____ State: ____ Zip: _____

SS #: _____ Driver's License #: _____ Date Employed: _____

Name of Employer: _____ Union or Local #: _____ Telephone: Work: _____ Home: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Dental Ins. Company: _____ Group #: _____ Policy/ID #: _____

## Secondary Dental Coverage Information

**If you do NOT have secondary coverage, please check this box: ☐**

Name of Insured: _____ Relationship to Patient: _____ Birthdate: ___/___/___

Address (if different from above): _____ City: _____ State: ____ Zip: _____

SS #: _____ Driver's License #: _____ Date Employed: _____

Name of Employer: _____ Union or Local #: _____ Telephone: Work: _____ Home: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Dental Ins. Company: _____ Group #: _____ Policy/ID #: _____

# DENTAL HISTORY

**Please answer each question by circling Yes or No.**

Do you have a specific dental problem or chief complaint? Describe: _____ Yes No

Do you have dental examinations on a routine basis? When was your last visit? _____ Yes No

Do you think you have cavities or gum disease? _____ Yes No

Do you brush and floss on a routine basis? Describe: _____ Yes No

Do your gums ever bleed? Describe: _____ Yes No

Do you like your smile? Why? _____ Yes No

Do you want to keep your remaining teeth? _____ Yes No

Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No

Have your past experiences in a dental office been positive? _____ Yes No

Name of previous dentist: _____ Date of last full mouth x-ray series: _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Date _____ Signature: _____

(If patient is a minor, include printed name and signature of parent or legal guardian)

**DO NOT WRITE IN THIS SPACE**

# HEALTH HISTORY

Patient Name: _____ Patient #: _____ Date: _____
Last First M

Please answer each question by checking the appropriate box or circling Yes or No.

1 Are you in good health? ..... Yes No
2 Date of last physical examination: _____
3. Are you now under the care of a physician? ..... Yes No
If yes, what is the condition being treated? _____
Doctor's name: _____ Telephone #: _____
4. Have you ever had any serious illness or operation or been hospitalized? ..... Yes No
Please explain: _____
5 Are you taking any medication? ..... Yes No
If yes, what? _____ What dosage? _____
6. Are you using any recreational drugs (e.g., marijuana, cocaine) or controlled substances? ..... Yes No
If yes, what? _____
7. Have you ever been premedicated with antibiotics for your dental treatment? ..... Yes No
8. Are you sensitive or allergic to any drugs or materials? ☐ Penicillin ☐ Tetracycline ☐ Erythromycin
☐ Aspirin ☐ Codeine ☐ Latex ☐ Other If Other, please list: _____ ..... Yes No
9 Do you have or have you had any of the following: Please check "Y" for Yes or "N" for No — answer all conditions:

| | | | |
|---|---|---|---|
| ☐ Y ☐ N AIDS | ☐ Y ☐ N Cortisone Medicine | ☐ Y ☐ N Hemophilia | ☐ Y ☐ N Respiratory Disease |
| ☐ Y ☐ N Allergies or Hives | ☐ Y ☐ N Diabetes | ☐ Y ☐ N Hepatitis or Jaundice | ☐ Y ☐ N Rheumatic Fever |
| ☐ Y ☐ N Allergies to Metals | ☐ Y ☐ N Difficulty in Swallowing | ☐ Y ☐ N Herpes | ☐ Y ☐ N Rheumatism |
| ☐ Y ☐ N Anemia | ☐ Y ☐ N Drug Addiction | ☐ Y ☐ N High Blood Pressure | ☐ Y ☐ N Sickle Cell Disease |
| ☐ Y ☐ N Angina Pectoris | ☐ Y ☐ N Emphysema | ☐ Y ☐ N HIV Positive | ☐ Y ☐ N Sinus Trouble |
| ☐ Y ☐ N Arthritis | ☐ Y ☐ N Epilepsy or Seizures | ☐ Y ☐ N Joint Replacement | ☐ Y ☐ N Stomach Ulcers |
| ☐ Y ☐ N Artificial Heart Valve | ☐ Y ☐ N Excessive Bleeding | ☐ Y ☐ N Kidney Disease | ☐ Y ☐ N Stroke |
| ☐ Y ☐ N Asthma | ☐ Y ☐ N Fainting Spells or Seizures | ☐ Y ☐ N Liver Disease | ☐ Y ☐ N TMJ |
| ☐ Y ☐ N Blood Disease | ☐ Y ☐ N Glaucoma | ☐ Y ☐ N Mental Disorder | ☐ Y ☐ N Thyroid Disease |
| ☐ Y ☐ N Blood Transfusion | ☐ Y ☐ N Hay Fever | ☐ Y ☐ N Mitral Valve Prolapse | ☐ Y ☐ N Tonsillitis |
| ☐ Y ☐ N Bruise Easily | ☐ Y ☐ N Head Injuries | ☐ Y ☐ N Nervous Disorders | ☐ Y ☐ N Tuberculosis |
| ☐ Y ☐ N Chemotherapy | ☐ Y ☐ N Heart Ailments or Attack | ☐ Y ☐ N Pain in Jaw Joints | ☐ Y ☐ N Tumors or Growths |
| ☐ Y ☐ N Cold Sores | ☐ Y ☐ N Heart Failure | ☐ Y ☐ N Psychiatric Treatment | ☐ Y ☐ N Venereal Disease |
| ☐ Y ☐ N Congenital Heart Lesions | ☐ Y ☐ N Heart Murmur | ☐ Y ☐ N Radiation Treatment | |

10. Do you wear a cardiac pacemaker, or have you had heart surgery? If yes, please explain: _____ ..... Yes No
11. Do you smoke, chew, use snuff or any other forms of tobacco? ☐ Cigarettes ☐ Cigars ☐ Chew ☐ Snuff ☐ Other ..... Yes No
If yes, how much? _____
12. Do you consume alcoholic beverages? If yes, how much? _____ ..... Yes No
13. Are you taking or scheduled to begin taking medications for Osteoporosis? ..... Yes No
(such as Fosamax, Actonel, Atelvia, Boniva, reclast, Prolia, etc.)
If so, What? _____
14. Are you pregnant? If yes, how many months? _____ ..... N/A Yes No
15. Do you have any problems associated with your menstrual period? ..... N/A Yes No
16. Do you take birth control pills? ..... N/A Yes No
17. Is there anything we should know about your health that is not mentioned above? ..... Yes No
Please explain: _____

**1st** I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Date: _____ Signature: _____
(If patient is a minor, include printed name and signature of parent or legal guardian)

**2nd** *UPDATE – Since your last visit:*

1. Have you seen a medical doctor? ..... Yes No
2. Have you had a change in any medication? ..... Yes No
3. Have you had a change in any medical condition or had surgery? ..... Yes No

*If yes, please explain:* _____

Date: _____ Signature: _____

**3rd** *UPDATE – Since your last visit:*

1. Have you seen a medical doctor? ..... Yes No
2. Have you had a change in any medication? ..... Yes No
3. Have you had a change in any medical condition or had surgery? ..... Yes No

*If yes, please explain:* _____

Date: _____ Signature: _____

**DO NOT WRITE IN THIS SPACE**

| | DATE | B.P. | PULSE | REVIEWED BY | DENTIST'S COMMENTS |
|---|---|---|---|---|---|
| 1st | | / | | | |
| 2nd | | / | | | |

# INFORMED CONSENT FOR DENTAL TREATMENT

## FILLINGS

BENEFITS:
- Eliminates decay
- Relieve pain
- Fill in a hole or space in a tooth
- Cover eroded areas
- Protect a sensitive surface

POSSIBLE COMPLICATIONS:
- Tooth may abscess from the filling
- May fracture the tooth
- Tooth may be sensitive to temperature changes
- Toxicity from silver fillings is alleged by some
- Filling may fall out

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
- May lose the tooth
- Tooth may fracture
- Decay will get larger
- Pain will get worse
- May result in need for a root canal

ALTERNATIVES:
- Temporary filling
- Extraction

## EXTRACTIONS

BENEFITS:
- Last resort for non-salvageable tooth
- Eliminate pain
- Remove teeth that are out of position
- Eliminate infection

POSSIBLE COMPLICATIONS:
- Fractured particles may remain
- Irritation to nerves may cause temporary or permanent numbness
- Part or all of tooth may be lodged in sinus, requiring more surgery
- Bad infections may take a long time to clear up
- Jaw may be stiff and difficult to open for a time
- If jawbone is very weak it may fracture

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
- Spread of infection
- Swelling
- Pain

ALTERNATIVES:
- None

## X-RAYS

BENEFITS:
- More complete diagnosis
- Can find hidden problems
- Can make a determination of treatment
- X-rays taken by qualified personnel

POSSIBLE COMPLICATIONS:
- Exposure to x-ray radiation (minimal)
- X-ray pictures remain the property of the dental office

CONSEQUENCES OF NOT HAVING THE WORK DONE OR POSTPONING:
- Can not perform dental services

ALTERNATIVES:
- None

## CLEANING - SCALING

BENEFITS:
- Look nicer
- Clean mouth
- Eliminate odors
- Prevents gum disease
- Some portions may be performed by auxiliary personnel

POSSIBLE COMPLICATIONS:
- Sensitive teeth
- Feeling of spaces between teeth
- Filling may be loosened (normal if filling was ready to fall out)

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
- Stains on teeth
- Odors
- Gum disease
- Will lose teeth sooner

ALTERNATIVES:
- None

## BONDED FACINGS

BENEFITS:
- Aesthetics - they look nice
- Cover crooked teeth
- Close spaces and gaps
- Cover discolored teeth

POSSIBLE COMPLICATIONS:
- Edges can stain after a time and need to be freshened up (additional fee)
- Breakage can occur, resulting in need for remake
- Difficult to remove

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
- None (other than appearance)

## ROOT CANAL

BENEFITS:
- Eliminate infection
- Relieve pain
- Save the tooth

POSSIBLE COMPLICATIONS:
- Tooth may darken (from previous injury)
- Postoperative pain and infection
- Undiagnosable root fracture means failure and extraction
- Undiagnosable auxiliary canal means failure and extraction
- Periodontal (gum) involvement may mean failure and extraction

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
- Extraction of tooth

ALTERNATIVES:
- Extraction
- Bridgework

## GUM SURGERY

BENEFITS:
- Eliminate infection
- Reduce food pockets around teeth
- Eliminate foul odors
- Reduce overgrown tissue
- Can eliminate tartar effectively

POSSIBLE COMPLICATIONS:
- May need to be repeated after a time
- Some pain after procedure
- Might lose teeth if they don't respond to treatment

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
- Will lose teeth sooner
- May not get rid of infection

ALTERNATIVES:
- More frequent appointments for scaling

## BLEACHING

BENEFITS:
- Makes the tooth look lighter

POSSIBLE COMPLICATIONS:
- Slight sensitivity of tooth after procedure
- May need to be repeated after a time due to darkening
- Irritation of gums from the bleach

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
- None

ALTERNATIVES:
- Crowns
- Bonded facings

## DENTURES

BENEFITS:
- Replaces missing teeth
- Improves chewing
- Makes you look nicer

POSSIBLE COMPLICATIONS:
- Dentures sometimes move while eating
- Denture may crack
- Teeth may come out of denture
- Sore areas
- Dentures may loosen over time requiring reline
- Plastic and/or teeth may stain over time
- Difficult to get used to

CONSEQUENCES OF NOT HAVING THE WORK DONE OR POSTPONING:
- Gum ridges will shrink
- Inefficient chewing of food
- Poor appearance

ALTERNATIVES:
- In rare cases, an implant

## ORTHODONTIC APPLIANCES

BENEFITS:
- Makes you look nicer
- Improve oral hygiene

POSSIBLE COMPLICATIONS:
- Loosening of teeth
- Tooth may not move into desired position
- Tooth may abscess form movement

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
- None

ALTERNATIVES:
- Bridgework
- Orthodontic specialist

I have read the preceding and I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with my dental care and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

_____

Signature (Parent or guardian if minor)

_____

Date

# Robert Sirotnik, DDS

4191 Riverview Dr. Riverside, CA 92509
951-683-0333

## Consent for Patient Contact

I, _____ hereby give my consent for Dr. Sirotnik and his staff to contact me regarding appointments and confidential health information via (please check all that apply):

- ☐ Message with spouse / friend / caregiver _____
- ☐ Mail
- ☐ Answering Machine / Voicemail – home / work (please circle)
- ☐ Fax # _____
- ☐ Cell Phone # _____
- ☐ E-mail Address _____
- ☐ DO NOT CONTACT ANYONE OTHER THAN ME PERSONALLY

_____
Patient Name (please print)

_____ _____
Patient Signature (Parent or Guardian) Date

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

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