



## HEALTH QUESTIONNAIRE

Patient Name \_\_\_\_\_  
 Sex \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Date \_\_\_\_\_ Occupation \_\_\_\_\_  
 Marital Status \_\_\_\_\_

### Directions

Please circle the appropriate answer to the questions and fill in the blanks where indicated. Answer all questions and blanks completely.

Answers to the following questions are for our records and will be considered confidential.

1. Are you in good health..... Yes No
  - A. Has there been any change in your general health..... Yes No
2. My last physical examination was on \_\_\_\_\_
3. Are you now under care of a physician..... Yes No
  - A. If so, what is the condition being treated \_\_\_\_\_
4. The name and address of my physician is \_\_\_\_\_  
 \_\_\_\_\_
5. Have you had any serious illness or operation..... Yes No
  - A. Is so, what was the illness or operation: \_\_\_\_\_  
 \_\_\_\_\_
6. Have you been hospitalized or had serious illness within the last (5 ) years..... Yes No
  - A. Do you have a persistent cough or cough up blood..... Yes No
  - B. Low Blood Pressure..... Yes No
  - C. Venereal Disease..... Yes No
  - D. Aids or HIV..... Yes No
  - E. Other \_\_\_\_\_
7. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma..... Yes No
  - A. Do you bruise easily..... Yes No
  - B. Have you ever requires a blood transfusion..... Yes No
 If so, explain the circumstances \_\_\_\_\_
8. Do you have any blood disorder such as anemia..... Yes No
9. Have you had surgery or X-ray treatment for a tumor, growth or other condition of your mouth or lips..... Yes No
10. Are you taking any drug or medication..... Yes No
  - If so, what \_\_\_\_\_
11. Are you taking any of the following:
  - A. Antibiotics or sulfa drugs..... Yes No
  - B. Anticoagulants (blood thinners)..... Yes No
  - C. Medicine for high blood pressure..... Yes No
  - D. Cortisone (steroids)..... Yes No
  - E. Tranquilizers..... Yes No
  - F. Aspirin..... Yes No
  - G. Insulin, Tolbutamide (Orinasc) or similar drug..... Yes No
  - H. Digitalis or drugs for heart trouble..... Yes No
  - I. Nitroglycerin..... Yes No
  - J. Fen-phen (now, or in the past)..... Yes No
  - K. Oral contraceptives..... Yes No
 If so, what are you using \_\_\_\_\_
- L. Other \_\_\_\_\_

12. Do you have heart murmur/mitral valve prolapse.... Yes No
13. Do you have any implants and/or prosthesis (i.e. knee joints, elbow pins, etc.)..... Yes No
  - If so, explain \_\_\_\_\_
14. Do you drink any alcoholic beverages..... Yes No
15. Do you smoke..... Yes No
  - If so, how much \_\_\_\_\_
16. Do you have or have had any of the following diseases or problems:
  - A. Rheumatic fever or rheumatic heart disease..... Yes No
  - B. Congenital heart lesions..... Yes No
  - C. Cardiovascular disease (heart trouble, heart attack, coronary occlusion, high blood pressure, arteriosclerosis, stroke)..... Yes No
    1. Do you have pain in the chest upon exertion ..... Yes No
    2. Are you ever short of breath after mild exercise..... Yes No
    3. Do you get short of breath when you lie down or do you require extra pillows when you sleep..... Yes No
  - D. Allergy..... Yes No
  - E. Asthma or hay fever..... Yes No
  - F. Hives or skin rash..... Yes No
  - G. Fainting spells or seizures..... Yes No
  - H. Diabetes..... Yes No
    1. Do you have to urinate (pass water) more than six times a day..... Yes No
    2. Are you thirsty much of the time..... Yes No
    3. Does your mouth frequently become dry..... Yes No
  - I. Hepatitis, jaundice or liver disease..... Yes No
  - J. Arthritis..... Yes No
  - K. Inflammatory rheumatism (painful, swollen joints)... Yes No
  - L. Stomach Ulcers..... Yes No
  - M. Kidney Trouble..... Yes No
  - N. Tuberculosis..... Yes No
17. Are you allergic or have reacted adversely to:
  - A. Local anesthetic..... Yes No
  - B. Penicillin or other antibiotics..... Yes No
  - C. Barbiturates, sedatives, or sleeping pills..... Yes No
  - D. Sulfa drugs..... Yes No
  - E. Aspirin..... Yes No
  - F. Iodine..... Yes No
  - G. Latex..... Yes No
  - H. Other \_\_\_\_\_

18. Have you had any serious trouble associated with previous dental treatment..... Yes No
  - If so, Explain \_\_\_\_\_

19. Are you pregnant or could you be..... Yes No
  - If so, when are you due? \_\_\_\_\_

I certify to the best of my knowledge that the above information is correct and that if there are any changes in the above, I agree to notify my dentist before my next visit.

Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Doctor \_\_\_\_\_ Date \_\_\_\_\_

Updates:		
Patient/Guardian _____	Doctor's Initials _____	Date _____
Patient/Guardian _____	Doctor's Initials _____	Date _____
Patient/Guardian _____	Doctor's Initials _____	Date _____

## Patient Acknowledgment of receipt of Dental Materials Fact Sheet

I, \_\_\_\_\_, acknowledge that I have received from \_\_\_\_\_  
a copy of the Dental Materials Fact Sheet dated October 2001.  
patient name dentist or dental office name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

*The following document is the Dental Board of California's Dental Materials Fact Sheet. The Department of Consumer Affairs has no position with respect to the language of this Dental Material Fact Sheet, and its linkage to the DCA web site does not constitute an endorsement of the content of this document.*

### SAMPLE

*The following document is the Dental Board of California's Dental Materials Fact Sheet. The Department of Consumer Affairs has no position with respect to the language of this Dental Materials Fact Sheet, and its linkage to the DCA Web site does not constitute an endorsement of the content of this document.*

## The Dental Board of California Dental Materials Fact Sheet

Adopted by the Board on October 17, 2001

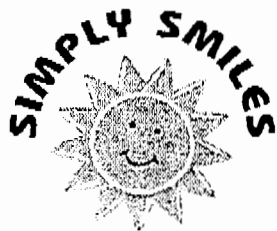
As required by Chapter 801, Statutes of 1992, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be a complete guide to dental materials science.

The most frequently used materials in restorative dentistry are amalgam, composite resin, glass ionomer cement, resin-ionomer cement, porcelain (ceramic), porcelain (fused-to-metal), gold alloys (noble) and nickel or cobalt-chrome (base-metal) alloys. Each material has its own advantages and disadvantages, benefits and risks. These and other relevant factors are compared in the attached matrix titled "Comparisons of Restorative Dental Materials." "A Glossary of Terms" is also attached to assist the reader in understanding the terms used.

The statements made are supported by relevant, credible dental research published mainly between 1993 - 2001. In some cases, where contemporary research is sparse, we have indicated our best perceptions based upon information that predates 1993.

The reader should be aware that the outcome of dental treatment or durability of a restoration is not solely a function of the material from which the restoration was made.

The durability of any restoration is influenced by the dentist's technique when placing the restoration, the ancillary materials used in the procedure, and the patient's cooperation during the procedure. Following restoration of the teeth, the longevity of the restoration will be strongly influenced by the patient's compliance with dental hygiene and home care, their diet and chewing habits.



# Stadium Dental & Orthodontics

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11897 Foothill Blvd., Suite A • Rancho Cucamonga, CA 91730  
(909) 476-9678 • [www.simplysmiles.com](http://www.simplysmiles.com)

## WARNING ABOUT AMALGAM (silver) FILLING

Amalgam fillings contain a chemical element known to the state of California to cause birth defects or other reproductive harm. Please ask us about alternative material if you do not wish to have amalgam fillings in your teeth. For example, you may have resin composite, porcelain or gold materials as alternatives to amalgam fillings. There may be increased fees with the use of these other materials.

Having read the above statement, I CONSENT to the use of silver amalgam fillings.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I DO NOT consent to the use of silver amalgam fillings.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# Stadium Dental

{NAME OF PRACTICE}

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

### SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Patient #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

### SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: SeKhar Chakka, DDS.

Telephone: (909) 476-9678 Fax: (909) 481-0040

E-mail: \_\_\_\_\_

Address: 11897 Foothill Blvd, Ste #A R.C. CA. 91730

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

### SIGNATURE

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature \_\_\_\_\_ Date \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**

**Include completed Consent in the patient's chart.**

## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 11/1/02, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

# Stadium Dental & Orthodontics

## General Dentistry Informed Consent

Dentist: \_\_\_\_\_ Patient: \_\_\_\_\_

### 1. WORK TO BE DONE

I understand that I am having the following work done: Fillings [ ], Crowns [ ], Bridges [ ], Extractions [ ], Impacted teeth removed [ ], Root Canals [ ], Dentures [ ], X-rays [ ], Other \_\_\_\_\_ (Initials \_\_\_\_\_)

### 2. DRUGS AND MEDICATION

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. (Initials \_\_\_\_\_)

### 3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. (Initials \_\_\_\_\_)

### 4. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery) and I authorize the Dentist to remove the following teeth \_\_\_\_\_ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, so of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (Parasthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility. (Initials \_\_\_\_\_)

### 5. CROWNS, BRIDGES AND CAPS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation. (Initials \_\_\_\_\_)

### 6. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the tooth which does not necessarily effect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stresses vented in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all effort to save it. (Initials \_\_\_\_\_)

### 7. PERIODONTAL LOSS (TISSUE AND BONE)

I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have future adverse effect on my periodontal condition. (Initials \_\_\_\_\_)

### 8. FILLINGS

I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. If the sensitivity continues, I understand that a root canal may be needed, even though the tooth may not have hurt prior to the filling being done. (Initials \_\_\_\_\_)

### 9. DENTURES

I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate denture (placement of denture immediately after extractions) may be painful. Immediate denture may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. (Initials \_\_\_\_\_) I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days, there will be additional charges. (Initials \_\_\_\_\_)

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney fees, collection fees, or court costs that may be incurred to satisfy this obligation.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Signature of Doctor \_\_\_\_\_ Witness \_\_\_\_\_