Patient Acknowledgment of receipt of Dental Materials Fact Sheet

I, _____, acknowledge that I have received / read from Dr. Ghotanian's Dental Office
Patient Name

a copy of the Dental Materials Fact Sheet.

_____ _____
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.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I have received a copy of Dr. Ghotanian's 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).

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out the following forms as completely as you can. If you have any questions we will be glad to assist you. We look forward to working with you in maintaining your oral health.

Patient Information

Date_____

Name: Last_____First_____M.I._____

ID/SS#____ /___ /____ Driver's License_____Sex: M___ F___ Age_____ Birth date _____

Address_____City _____State ____ Zip _____

Home Telephone (___)_____Work Telephone (___)_____Cell (____)_____

Email _____

Employer _____Occupation _____

EMERGENCY CONTACT: Name _____Phone (____)_____

Whom may we thank for referring you? _____

Financial Responsibility

Subscriber's Name_____ID/SS# ____ /___ /____ Birth Date _____

Address (if different from patient's) _____

Subscriber's Employer _____ Occupation _____

Insurance Co _____ Group # _____

Relationship to Patient _____ Is patient covered by additional insurance? Yes ___ No ___

ASSIGNMENT AND RELEASE

I. the undersigned certify that I (or my dependent) have insurance coverage with above named insurance company and assign directly to Dr. Ghotanian all insurance benefits. I understand that I am financially responsible for all charges whether or not covered by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I also understand that all payments of services rendered are due upon commencement. By signing below, responsible party accepts all financial reponsibility.

_____ _____ _____

Responsible Party Signature | Relationship | Date

Office Policy

If unable to keep any appointments kindly give 24-hr notice otherwise we reserve the right to charge $50 per half hour for time appointed.

Responsible Party Signature _____

Dental History

Reason for today's visit _____

_____

Former Dentist_____

City/State_____

Date of last dental visit _____

Date of last dental x-rays_____

Date of last dental cleaning_____

Check if you have had any of the following:

Bad Breath	Yes ____ No ____
Bleeding Gums	Yes ____ No ____
Cigarette, pipe or cigar smoking	Yes_ ___ No ____
Loose teeth or broken filling	Yes ____ No ____
Periodontal treatment	Yes ____ No ____
Sensitive to cold, heat or sweets	Yes ____ No ____
Sores or growth in mouth	Yes ____ No ____
How often do you floss/brush?	_____

Name _____

Patient Consent To Treatment

Rene Ghotanian. DDS, PC
Tina Ghotanian, DDS, PC
5363 Baiboa Blvd. Suite 346, Encino CA 91316 (818) 990-3551
500 East Olive Ave. Suite 460, Burbank CA 91501 (818) 846-2600
10916 Riverside Drive, Toluca Lake CA 91602 (8181 762-9966
212 So El Molino Pasadena, CA 91101 (626)792-7900

In reading and signing this form, it is understood that ENGLISH is the language that I understand and use to communicate. **Initials** _____

1. Drugs, Medications, and Anesthesia

I understand that antibiotics, analgesics, and other medications may cause adverse reactions, some of which are, but are not limited to, redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage and cardiac arrest. I understand that medications, drugs, and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to consume alcohol nor operate any vehicles or hazardous devices while taking medications and/or drugs or unti! fully recovered from their effects (this includes a period of at least 24 hours after the release of my surgery). I understand that occasionally upon injection of a local anesthetic I may have prolonged, persistent anesthesia and/or irritation to the area of injection, including a hematoma or bruising. I understand that if I select to utilize Nitrous Oxide, “Atarax”, Chloryl Hvdrate, “Zanax”, Ativan or any other sedative drugs, possible risks will include, but are not limited to loss of consciousness, obstruction of airway, anaphylactic shock, and cardiac arrest. I understand that somebody must drive me home after sedation, and that someone needs to watch me closely for a period of 5 to 10 hours following my dental appointment to observe for possible deleterious side effects.

Initials _____

2. Hygiene and Periodontics (Gums and Bone Loss)

I understand that the long term success of treatment and status of my oral health, oral condition, and prognosis depends on my efforts at proper oral hygiene (brushing & flossing) and maintaining diagnosed recall visits for cleanings and radiographs.

Initials _____

PERIODONTICS: I understand that I have a Periodontal condition causing gum and bone inflammation and/or loss, which can lead to the loss of my teeth or tooth, supporting oral structure, systemic infection, and other complications. All various treatment plans have been explained to me including scaling and root planing, gum surgery, tooth replacement and/or extractions. I also understand that although these treatments have a high degree of success they cannot be guaranteed. Occasionally treated teeth may require extraction. All possible complications and consequences present and future have been explained to me.

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 may be necessary during or following a routine restorative procedure. I give permission to the dentist to make any necessary changes or additions. I understand that the dentist will make every effort to inform me should this situation arise.

Initials _____

4. Removal of Teeth

I understand that the purpose of this surgery is to treat and possibly correct my diseased oral tissues. The doctor has advised me that if this condition persists without treatment or surgery my present oral condition will probably worsen with time. Potential risks of surgery includes, but are not limited to the following:

- Post-operative discomfort, swelling, prolonged bleeding, tooth sensitivity to hot and cold, shrinkage of gums (possibly exposing crown margins), tooth mobility, delayed healing (dry socket), and/or infection (requiring prescription medication or additional treatments).
- Injury to adjacent teeth, caps or fillings (requiring the re-cementation of crowns, replacement of fillings, new crowns, or extractions), or injury to other tissues not within the surgical area.
- Limitation of mouth opening, stiffness of facial and/or neck muscles, change in bile, and/or Temporamandibular joint (jaw joint) difficulty, with possibility of surgery or physical therapy can occur with surgery. Residual root fragments or bone Spicules left when complete removal would require extensive surgery or unnecessary complications.
- Possible bone fracture may occur which may require wiring or surgical treatment.
- An opening of the maxillary sinus (a normal cavity situated above the upper teeth) requiring additional surgery (i.e. Sinus lift or sinus closure procedure).
- Injury to the nerve underlying the teeth resulting in itching, numbness, or burning of the lips, chin, gums, cheek, teeth and/or tongue on the operated side. This may persist for several weeks, months or in remote instances permanently.

I give my consent for the doctor to perform the treatment, procedure, or surgery previously explained to me and/or procedures necessary or advisable to complete the planned operation. If any unforeseen condition should arise in the course of operation, calling for the doctor’s judgment or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever s/he may deem advisable. This may include a referral to a specialist, for which I would be responsible for the fees of the referred specialist.

Initials _____

5. Fillings

I have been advised of the need for fillings, either silver, mercury amalgam or composite (white/plastic) to replace tooth structure lost to decay, erosion or abrasion. I understand that with time fillings will need to be replaced due to wearing of material, oral flora or stress of chewing. In cases where very little tooth structure remains or existing tooth structure fractures off I may need to receive more extensive treatment (such as onlay, root canal therapy, post, build-up and crown), which would necessitate a separate charge. I understand that the silver amalgam fillings are an acceptable procedure according lo the American Dental Association guidelines and as such is a treatment done by the doctor. The advantages and disadvantages of alternate materials have been explained to me.

Initials _____

X _____ **X** _____ **X** _____ **X** _____ **X** _____

6. Endodontic Treatment (Root Canal Therapy)

The purpose and method of root canal therapy has been explained to me, as well as reasonable alternative treatments, and the consequences of non-treatment I understand that following root canal therapy my tooth will be brittle and susceptible lo fracture, thus, my tooth must be protected against fracture with the placement of a crown (cap) over the tooth. I understand that treatment risks can include but are not limited to the following:

- Post treatment discomfort lasting a few hours to several days for which medication will be prescribed if deemed necessary by the doctor,
- Post treatment swelling of the gum or facial area in the vicinity of the treated tooth, either of which may persist for several days or longer.
- Infection

- Restricted jaw opening
- Breakage of root canal instruments within the nerve chamber during treatment, which may in the judgment of the doctor to be left in the treated root canal or bone of the filling material, or it may require additional surgical treatment or extraction.
- Perforation of the root canal with instruments, which may require additional surgical treatment, premature tooth loss or extraction.
- Risk of temporary or permanent numbness in the area

If an "open and medicate" or pulpotomy procedure is performed, I understand that this is not a permanent treatment and I need to return to finish the root canal therapy and pay for this treatment If root canal therapy is not finalized I expose myself lo infection and/or tooth loss. If failure of root canal therapy occurs the treatment may have to be redone, or root end surgery maybe required, or potentially the tooth may have to be extracted. **Initials** _____

7. Crown, Onlays, and Bridges (Caps)

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I understand that at times during the preparation of a tooth for a crown, bridge or onlay, a pulp exposure may occur requiring possible root canal therapy, I understand that like natural teeth crowns, onlays, and bridges need to be kept clear, with proper oral hygiene and periodic cleanings, otherwise decay may develop underneath and/or around the margins of the restoration leading to further dental treatments. I also understand that it is my responsibility to return within two weeks for the delivery) of the final restoration. Teeth may move with in a couple of weeks thus resulting in the new crown not to fit and costs for the refabrication of a new crown will be passed to the patient. The temporary restoration placed on the initial visit is not adequate for long term and can result in tooth loss if final crown is not delivered. **Initials** _____

X _____ X _____ X _____ X _____ X _____

8. Dentures Complete or Partials

The problems of wearing dentures have been explained to me including looseness, soreness, possible breakage, and relining due to tissue change, follow up appointments are an integral plan of maintenance and success of a prosthetic appliance. Persistent sore spots should be immediately examined by the doctor. I further understand that surgical intervention (i.e. Tori and exostosis (bone) removal and bone recontouring) may be needed for dentures to be properly fitted. I also understand that due to bone loss or other complicating factors I may never be able to wear dentures to my satisfaction. Immediate dentures delivered after multiple extractions will need numerous relines in order for the dentures to be readapted to the healing tissue changes. **Initials** _____

9. Pedodontics (Children's Dentistry)

I understand that the following procedures are routinely used by the doctor and are commonly accepted procedures in the dental profession.

- Positive reinforcement - rewarding the child who portrays desirable behavior, by the use of compliments, praise, hugs, or tokens or toys.
- Voice Control - The attention of a disruptive child is gained by changing the tone or increasing the volume of the doctor's voice.
- Hand Over Mouth Exercise - The disruptive child is told that a hand is to be placed over the child's mouth and is to be removed when the disruptive noise stops. If the noise resumes the hand again is placed on the mouth and the exercise is repeated. At no time is the airway ever restricted.
- Physical Restraint - Restraining the child's disruptive movements by holding down their arms, upper body, head and/or legs with the help of the dental assistant.
- Oral Sedation - Oral sedation medications are administered to children to help them relax, With their use the parent/guardian must understand that the child should not eat or drink for a period of four hours prior to the sedation appointment. The parent/guardian must accompany and escort the child home after treatment and observe behavior.

I understand that with the use of anesthetic injections to numb the tooth for the dental procedure the possibility exists that the child may inadvertently bite their lip or cheek causing injury. I understand the need to return to the office if swelling and/or pain does not diminish completely after sufficient time I also understand the need to return to the office after three months following nerve treatment on a "baby tooth" for evaluation and possible extraction. **Initials** _____

I UNDERSTAND THAT DENTISTRY IS NOT AN EXACT SCIENCE AND THEREFORE NO GUARANTEES OR ASSURANCES HAVE OR CAN BE GIVEN FOR THE PROPOSED TREATMENT TO BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HIS/HER CARE, REALIZING THAT ANY LACK OF COOPERATION COULD RESULT IN LESS THAN OPTIMUM RESULTS. THERE HAVE BEEN NO PROMISES MADE TO ME NOR ANY DURESS OR PRESSURE BROUGHT UPON ME TO SIGN THIS AGREEMENT,

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE AND OPPOSING PAGE OF THE DOCUMENT, AND CONSENT TO THE OPERATION REFERRED AND EXPLAINED TO ME. I HAVE BEEN ENCOURAGED TO ASK QUESTIONS AND HAVE HAD THEM ANSWERED TO MY SATISFACTION.

I UNDERSTAND THAT RENE GHOTANIAN, D.D.S. PROFESSIONAL CORPORATION, AND TINA GHOTANIAN D.D.S., P.C, INCLUDING DR. GHOTANIAN AND HIS/HER STAFF PROVIDE DENTAL SERVICES WITHOUT DISCRIMINATION BASED ON RACE, RELIGION, COLOR, SEX. NATIONAL. ORIGIN, SEXUAL ORIENTATION, PHYSICAL AND MENTAL DISABILITY, AGE OR MARITAL STATUS AND PROTECT THE PRIVACY OF EACH OF THEIR PATIENTS,

I HEREBY AUTHORIZE THE DENTIST AND HIS/HER AUXILIARIES AND TO PROCEED WITH AND PERFORM THE DENTAL RESTORATIONS AND/OR TREATMENTS EXPLAINED TO ME, I UNDERSTAND THAT THIS IS ONLY AN ESTIMATE AND SUBJECT TO MODIFICATION DEPENDING ON UNFORESEEN OR UNDIAGNOSABLE CIRCUMSTANCES THAT MAY ARISE DURING THE COURSE OF TREATMENT. 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.

SHOULD ANY DISPUTE ARISE OVER DENTAL SERVICES PROVIDED TO ME, SAID DISPUTE WILL BE SUBMITTED TO PEER REVIEW BY THE LOCAL COMPONENT OF THE AMERICAN DENTAL ASSOCIATION. THE DECISION OF THE PEER REVIEW SHALL BE BINDING ON BOTH PARTIES.

Signature _____Relationship _____Date_____/_____/_____

Dr. Signature _____Date_____/_____/_____

Health History

Physician's Name_____ Date of last visit_____

Have you had any of the following:

Anemia	Yes	No	Hemophilia	Yes	No	**Women:**		
Arthritis, Rheumatism	Yes	No	Jaundice	Yes	No	Are you pregnant?	Yes	No
Artificial Heart Valves	Yes	No	Kidney Disease	Yes	No	Are you nursing?	Yes	No
Artificial Joints	Yes	No	Liver Disease	Yes	No	Taking birth control pills?	Yes	No
Asthma	Yes	No	Mitral Valve Prolapse	Yes	No			
Bruise Easily	Yes	No	Pacemaker	Yes	No	**Allergies:**		
Blood diseases	Yes	No	Psychiatric Care	Yes	No	Check if you are allergic to:		
Cancer or Tumors	Yes	No	Radiation Treatment	Yes	No			
Chemical Dependency	Yes	No	Respiratory Disease	Yes	No	Aspirin	Yes	No
Chemotherapy	Yes	No	Rheumatic Fever	Yes	No	Barbiturates	Yes	No
Circulatory Problems	Yes	No	Shortness of Breath	Yes	No	Codeine	Yes	No
Congenital Heart Lesions	Yes	No	Sinus Trouble	Yes	No	Iodine	Yes	No
Contact lenses	Yes	No	Stomach/Ulcer	Yes	No	Latex	Yes	No
Cough, persistent or bloody	Yes	No	Stroke	Yes	No	Penicillin	Yes	No
Diabetes	Yes	No	Swelling of Feet or Ankles	Yes	No	Sulfa	Yes	No
Emphysema	Yes	No	Swollen Neck Glands	Yes	No	Other _____		
Epilepsy / Fainting	Yes	No	Thyroid Problems	Yes	No			
Glaucoma	Yes	No	Tonsillitis	Yes	No	**Notes:** (Do not write below)		
HIV/AIDS	Yes	No	Tuberculosis	Yes	No			
Headaches	Yes	No	Venereal Diseases	Yes	No			
Heart Murmur	Yes	No	Weight Loss, unexplained	Yes	No			
Heart Problems	Yes	No	Have you ever taken any					
Hepatitis Type	Yes	No	of the drugs referred to as					
Herpes	Yes	No	"fen-phen".	Yes	No			
High Blood Pressure	Yes	No	or bisphosphonates “Fosamax”	Yes	No			

List and date all surgeries, hospitalizations and medical conditions not listed above:

_____

_____

List any medications/supplements you are currently taking and their correlating diagnosis:

_____

_____

The information provided on both sides of this sheet is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in completion of this form.

Patient’s Signature _____ Date _____

Doctor’s Signature_____ Date _____

DO NOT COMPLETE

Changes _____ Dr._____ Date_____

Changes _____ Dr._____ Date_____

Changes _____ Dr._____ Date_____

Changes _____ Dr._____ Date_____

Changes _____ Dr._____ Date_____

Changes _____ Dr._____ Date_____