



Dadeland Dental Arts
SALEEM SIRRI, DDS

8950 SW 74th CT suite 1911
Miami, FL 33156

Welcome to our practice

Our office is dedicated to giving you a safe & comfortable dentistry that exceeds your expectations. Dr. Saleem Sirri is proud to be able to offer the latest in dental care combined with proven techniques. He and his team are deeply invested in your well-being.

To us, our patients are our family. We take the time to get to know you and your specific situation. It's important to us that you understand your treatment options so you can make a very well informed decision.

Welcome to Our Practice

Patient Information

Title First Name M.I. Last Name Suffix
I prefer to be called
Address City State Zip
Home Phone Cell Phone Business Phone Ext.
Preferred Contact # Social Security # Gender Male Female
Date of Birth / / Marital Status Single Married Divorced Widowed Separated
How did you find out about us?
Other family members seen by us:

Emergency Contact

Title First Name M.I. Last Name Suffix
Relationship to Patient
Home Phone Cell Phone Business Phone Ext.

Responsible Party

Who will be responsible for your account? Self Spouse Father Mother Other:
Title First Name M.I. Last Name Suffix
Address City State Zip
Home Phone Business Phone Ext.
Date of Birth / / Social Security # Driver's License #
Employer

Primary Insurance

Do you have a Primary Insurance? Yes No Does it have Dental Coverage? Yes No
Company Name
Company Address City State Zip
Company Phone # Group # (Plan, Local or Policy #)
Insured's Name Relationship to Patient
Insured's Date of Birth / / Insured's Employer
Insured's Employer Address

Secondary Insurance

Do you have a Secondary Insurance? Yes No Does it have Dental Coverage? Yes No
Company Name
Company Address City State Zip
Company Phone # Group # (Plan, Local or Policy #)
Insured's Name Relationship to Patient
Insured's Date of Birth / / Insured's Employer
Insured's Employer Address

Dental Information

Previous or Referring Dentist: _____ Phone Number: _____

When was your last dental visit? _____ What was done? _____

When were x-rays taken last? _____ When was your last dental cleaning? _____

Reason for today's visit: _____ Are you in pain? Yes No For how long? _____

Please rate your current dental health: Excellent Good Fair Poor

How do you feel about your smile? _____

How many times a day do you brush? _____ How many times a week do you floss? _____

What type of toothbrush do you use? Hard Medium Soft

Are you fearful of dental treatment? Yes No Please explain: _____

Have you ever had trouble getting numb or had reactions to local anesthetic? Yes No

Please describe: _____

Do your gums bleed? Yes No

Is your mouth dry? Yes No

Teeth sensitive to heat, cold, sweets, brushing, or flossing? Yes No

Have you noticed any bad tastes or bad breath? Yes No

Have you ever had periodontal (gum) treatments? Yes No

Have you had orthodontic (braces) treatment? Yes No

Does food tend to become caught between your teeth? Yes No

Have you had any problems associated with previous dental treatment? Yes No

Do you have earaches or neck pains? Yes No

Do you have any clicking, popping or discomfort in the jaw? Yes No

Have you noticed any loose or shifting teeth? Yes No

Have any of your family members had significant dental treatment or tooth loss? Yes No

Would you be concerned if you lost your teeth and had to wear false teeth? Yes No

Do you clench or grind your teeth? Yes No

Have you had headaches on a regular basis in the morning, evening, or after eating? Yes No

Have you had your bite adjusted? Yes No

Do you have sores or ulcers in your mouth? Yes No

Do you wear dentures or partials? Yes No

Have you ever had a serious injury to your head or mouth? Yes No

Do you participate in active recreational activities? Yes No

Health History

Please rate your current physical health: Excellent Good Fair Poor

Date of last physical exam _____ Are you now under the care of a physician? Yes No

Current Physician

What condition is being treated? _____

Physician Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

For Women

Are you pregnant? Yes No How many weeks? _____

Taking birth control pills or hormonal replacement? Yes No Are you nursing? Yes No

Have you had a serious illness, operation or been hospitalized in the past 5 years? Yes No

What was the illness or problem? _____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? Yes No

Please list any medications (prescription or over the counter) you are taking:

Name _____	For what condition? _____	Dosage _____
Name _____	For what condition? _____	Dosage _____
Name _____	For what condition? _____	Dosage _____
Name _____	For what condition? _____	Dosage _____
Name _____	For what condition? _____	Dosage _____

Do you need antibiotics prior to receiving dental care? Yes No Reason: _____

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Yes No

Date: _____ Have you had any complications? _____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? Yes No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes No Date treatment began: _____

Do you use controlled substances (drugs)? Yes No

Do you use tobacco (smoking, snuff, chew, bidis)? Yes No Are you interested in quitting? Yes No

Do you drink alcoholic beverages? Yes No How much do you typically drink in a week? _____

Alergies

Are you allergic to or have you had a reaction to:

Local anesthetics Yes No

Details: _____

Aspirin Yes No

Details: _____

Penicillin or other antibiotics Yes No

Details: _____

Barbiturates, sedatives, or sleeping pills Yes No

Details: _____

Sulfa drugs Yes No

Details: _____

Codeine or other narcotics Yes No

Details: _____

Metals Yes No

Details: _____

Latex (rubber) Yes No

Details: _____

Iodine Yes No

Details: _____

Hay fever/seasonal Yes No

Details: _____

Animals Yes No

Details: _____

Food Yes No

Details: _____

Other _____

Medical Conditions

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

AIDS / HIV Positive Yes No

Excessive Bleeding Yes No

Mitral Valve Prolapse Yes No

Alzheimer's Disease Yes No

Excessive Thirst Yes No

Pain in Jaw Joints Yes No

Anaphylaxia Yes No

Fainting Spells/Dizziness Yes No

Parathyroid Disease Yes No

Anemia Yes No

Frequent Cough Yes No

Psychiatric Care Yes No

Angina Yes No

Frequent Diarrhea Yes No

Radiation treatment Yes No

Arthritis/Gout Yes No

Frequent Headaches Yes No

Recent Weight Loss Yes No

Artificial Heart Valve Yes No

Genital Herpes Yes No

Renal Disease Yes No

Artificial Joint Yes No

Glaucoma Yes No

Rheumatic Fever Yes No

Asthma Yes No

Hay Fever Yes No

Rheumatism Yes No

Blood Disease Yes No

Heart Attack/Failure Yes No

Scarlet Fever Yes No

Blood Transfusion Yes No

Heart Murmur Yes No

Shingles Yes No

Breathing Problems Yes No

Heart Pace Maker Yes No

Sickle Cell Disease Yes No

Bruise Easily Yes No

Heart Trouble/Disease Yes No

Sinus Trouble Yes No

Cancer Yes No

Hemophilia Yes No

Spina Bifida Yes No

Chemotherapy Yes No

Hepatitis A Yes No

Stomach/Intestinal Disease Yes No

Chest Pains Yes No

Hepatitis B or C Yes No

Stroke Yes No

Cold Sores/Fever Blisters Yes No

Herpes Yes No

Swelling of Limbs Yes No

Congenital Heart Disorder Yes No

High Blood Pressure Yes No

Thyroid Disease Yes No

Convulsions Yes No

Hives / Rash Yes No

Tonsilitis Yes No

Cortisone Medicine Yes No

Hypoglycemia Yes No

Tuberculosis Yes No

Diabetes Yes No

Irregular Heartbeat Yes No

Tumors/ Growths Yes No

Drug Addiction Yes No

Kidney Problems Yes No

Ulcers Yes No

Easily Winded Yes No

Leukemia Yes No

Venereal Disease Yes No

Emphysema Yes No

Low Blood Pressure Yes No

Yellow Jaundice Yes No

Epilepsy or Seizures Yes No

Lung Disease Yes No

Do you have any disease, condition, or problem not listed above that you think we should know about? Yes No

Please explain: _____

Confirmation

I certify that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient Signature _____

OFFICE POLICIES

OFFICE HOURS – MONDAY-TUESDAY, WEDNESDAY, THURSDAY 7:30am-6pm.

Friday appointment for select extensive cases.

Hours are subject to change.

APPOINTMENTS – Dental treatment is a very personalized and time-intensive service and we reserve specific time in which to perform the procedures. When you schedule an appointment, it is your responsibility to keep that appointment. We will make an effort to contact you to remind you of your appointment, however, it is still your responsibility to show up whether you hear from us or not. If you have any questions, please call to verify. Please call at least 48 hours before and speak with a real person to cancel an appointment. If you are going to be late, please call us so we are aware of the situation. We understand that things happen, however, just as your time is valuable, our time is valuable. The charge for broken appointments with less than 48 hours notice is \$50 per half hour of appointment time. (If a patient does not show up for an appointment for which we have reserved the time, the patient does not get the treatment needed and someone else does not get the treatment they may have needed). We accommodate emergencies for our patients of record within 24 hours. We try to accommodate all who truly want and need to be seen.

X-RAYS AND EXAMINATIONS – It is required by law that we establish a baseline and diagnosis of your oral health prior to prescribing a “cleaning” appointment or other treatment visit. X-rays and an examination help us formulate the blueprint for your care and proper sequencing. We also may need photographs and diagnostic models to help us study your particular dental issues and plan treatment.

MEDICAL HISTORY – Please be sure that you give us your complete medical history and inform us of any changes. It is your responsibility to inform us of any medical alerts and any prescribed and over the counter medications.

CHILD VISITS - A parent needs to accompany minors under 18 years of age at the time of the appointment unless we have a written consent prior to the appointment that a relative or friend has authority.

FINANCIAL POLICY – Full payment is expected at the time service is rendered. We accept cash, checks, Visa, Master Card, Discover, and American Express. Returned checks will be charged a \$25.00 service fee.

I have read, had the opportunity to ask questions, and understand the office policy.

Patient Signature: _____ Date: _____



SALEEM SIRRI, DDS
8950 SW 74th CT Miami, FI 33156

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

****We reserve the right to decline treatment if you refuse to sign this Consent.****

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting Our office at (305)670-0641

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.

I, _____, hereby authorize Dadeland Dental Arts & Saleem Sirri, DDS

(print your name)

(hereby collectively referred to as "Practice") to use and disclose the entire medical record concerning _____.

(print patient's name)

I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. I understand that my records may be subject to re-disclosure by recipients and unprotected by federal or state law.

A copy of this signed and dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this consent.

I specifically authorize Practice to use and disclose verbally, by mail, fax or unencrypted email, the following types of super-confidential information as stated in the NOPP:

Initial where appropriate:

- _____ Alcohol and substance abuse diagnosis and treatment records
- _____ HIV records (including test results) and sexually transmissible disease
- _____ Psychotherapy records

_____/_____/_____/_____ / _____ / _____ / _____

Signature Print Name Relationship to Patient Date

Dadeland Dental Arts
SALEEM SIRRI, D.D.S., P.A.

LIST OF CURRENT MEDICATIONS

NAME: _____ DATE: _____

PLEASE LIST ANY AND ALL MEDICATIONS WITH STRENGTH,
DOSAGE AND REASON FOR MEDICATION.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

FINANCIAL POLICY
Dadeland Dental Arts
Saleem Sirri, D.D.S., P.A.

Doctor Sirri and his team at Dadeland Dental Arts would like to welcome you to our office. We strive to provide you with excellent dental care and our goal is to make your visits as pleasurable as possible.

Since we are **NOT** contracted or subscribe to any insurance companies, we are considered an **out-of-network** office. If you have an indemnity policy or Direct Reimbursement, those policies usually give you the most freedom to choose the dentist you want.

WE WILL NOT TREAT YOU OR RECOMMEND TREATMENT BASED ON WHAT INSURANCE WILL OR WILL NOT COVER.

By signing below you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes.
- Your account is to be kept current - All self-pay, estimated payments, and deductibles will be collected at the time of service.
- A returned check will result in a **\$25** service charge and **ALL FUTURE** payments must be paid in cash or by credit card.

IF YOU HAVE DENTAL INSURANCE COVERAGE:

We will submit your claims, however ***we must emphasize that as a dental provider, our relationship is with you, NOT your insurance company.*** Although we attempt to verify your dental benefits with your insurance company, please be advised this is only an estimate of your coverage based on the information given to us at the time of the inquiry.

By signing below you confirm that you understand:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified **before** your appointment.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy.
- If the claim is denied we ask that **YOU** call on your own behalf. It is more likely that your insurance company will explain to you, since you are the policy holder and premium payer.
- You are responsible for any non-covered charges not payable by your insurance.

Filing your insurance claims is a **COURTESY** extended to you. **ALL** charges are **ALWAYS YOUR RESPONSIBILITY** from the date services are rendered.

We realize that temporary financial problems may affect timely payment on your account. If such problems arise, we urge you to contact us promptly for assistance in the management of your account. We are here to help you.

Patient Name (Print)

Patient/Responsible Party Signature

Date