CONFIDENTIAL INFORMATION QUESTIONNAIRE

Please Print

PATIENT'S NAME LAST	FIRST	MIDDLE	SEX	DATE OF BIRTH

SOCIAL SECURITY NUMBER	HOME PHONE	CELL PHONE	EMAIL

PATIENT'S ADDRESS STREET	APT #	CITY	STATE	ZIP

MARITAL STATUS ☐ M ☐ S ☐ D ☐ W ☐ UNDER AGE 18	PATIENT'S/GUARDIAN'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET	CITY	STATE	ZIP	WORK PHONE OK TO CALL WORK ☐ YES ☐ NO

SPOUSE'S NAME LAST	FIRST	MIDDLE	SPOUSE'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET	CITY	STATE	ZIP	WORK PHONE OK TO CALL WORK ☐ YES ☐ NO

PERSON WE CAN CONTACT IN CASE OF EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME	RELATIONSHIP	WORK #	HOME #

OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE	WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE ☐ YES ☐ NO	INSURANCE COMPANY NAME	ADDRESS	PHONE

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SSN

GROUP/PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER ADDRESS

SECONDARY COVERAGE ☐ YES ☐ NO	INSURANCE COMPANY NAME	ADDRESS	PHONE

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SSN

GROUP/PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER ADDRESS

ASSIGNMENT & RELEASE:

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he so determines.

In consideration of the services rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policy.

I consent to the making of videotapes, photographs, and x-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature ______________________________ Date ______________

MEDICAL HISTORY

Patient Name ______________________ Nickname ______________ Age ______

Name of Physician/and their specialty ______________________

Most recent physical examination ______________________ Purpose ______________________

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:

		YES	NO
1.	hospitalization for illness or injury ______	☐	☐
2.	an allergic reaction to ☐ aspirin, ibuprofen, acetaminophen, codeine ☐ penicillin ☐ erythromycin ☐ tetracycline ☐ sulfa ☐ local anesthetic ☐ fluoride ☐ metals (nickel, gold, silver, ______) ☐ latex ☐ other ______		
3.	heart problems, or cardiac stent within the last six months ___	☐	☐
4.	history of infective endocarditis ______	☐	☐
5.	artificial heart valve, repaired heart defect (PFO) ______	☐	☐
6.	pacemaker or implantable defibrillator ______	☐	☐
7.	artificial prosthesis (heart valve or joints) ______	☐	☐
8.	rheumatic or scarlet fever ______	☐	☐
9.	high or low blood pressure ______	☐	☐
10.	a stroke (taking blood thinners) ______	☐	☐
11.	anemia or other blood disorder ______	☐	☐
12.	prolonged bleeding due to a slight cut (INR > 3.5) ______	☐	☐
13.	emphysema, shortness of breath, sarcoidosis ______	☐	☐
14.	tuberculosis, measles, chicken pox ______	☐	☐
15.	asthma ______	☐	☐
16.	breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17.	kidney disease ______	☐	☐
18.	liver disease ______	☐	☐
19.	jaundice ______	☐	☐
20.	thyroid, parathyroid disease, or calcium deficiency ______	☐	☐
21.	hormone deficiency ______	☐	☐
22.	high cholesterol or taking statin drugs ______	☐	☐
23.	diabetes (HbA1c = ______) ______	☐	☐
24.	stomach or duodenal ulcer ______	☐	☐
25.	digestive disorders (i.e. celiac disease, gastric reflux) ______	☐	☐
26.	osteoporosis/osteopenia (i.e. taking bisphosphonates) ___	☐	☐
27.	arthritis, rheumatoid arthritis, lupus ______	☐	☐
28.	glaucoma ______	☐	☐
29.	contact lenses ______	☐	☐
30.	head or neck injuries ______	☐	☐
31.	epilepsy, convulsions (seizures) ______	☐	☐
32.	neurologic disorders (ADD/ADHD, prion disease) ______	☐	☐
33.	viral infections and cold sores ______	☐	☐
34.	any lumps or swelling in the mouth ______	☐	☐
35.	hives, skin rash, hay fever ______	☐	☐
36.	STI / STD ______	☐	☐
37.	hepatitis (type ___) ______	☐	☐
38.	HIV / AIDS ______	☐	☐
39.	tumor, abnormal growth ______	☐	☐
40.	radiation therapy ______	☐	☐
41.	chemotherapy, immunosuppressive ______	☐	☐
42.	emotional problems ______	☐	☐
43.	psychiatric treatment ______	☐	☐
44.	antidepressant medication ______	☐	☐
45.	alcohol / street drug use ______	☐	☐

ARE YOU:

		YES	NO
46.	presently being treated for any other illness ______	☐	☐
47.	aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) ______	☐	☐
48.	taking medication for weight management (i.e. fen-phen)	☐	☐
49.	taking dietary supplements ______	☐	☐
50.	often exhausted or fatigued ______	☐	☐
51.	experiencing frequent headaches ______	☐	☐
52.	a smoker, smoked previously or use smokeless tobacco _	☐	☐
53.	considered a touchy person ______	☐	☐
54.	often unhappy or depressed ______	☐	☐
55.	FEMALE - taking birth control pills ______	☐	☐
56.	FEMALE - pregnant ______	☐	☐
57.	MALE - prostate disorders ______	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________ Date ______________

Doctor's Signature ______________________ Date ______________

DENTAL HISTORY

Name______________________________ Nickname______________________________ Age_________

Referred by__________________________ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist ______________________________ How long have you been a patient?__________ Months/Years

Date of most recent dental exam ______/______/______ Date of most recent x-rays ______/______/______

Date of most recent treatment (other than a cleaning) ______/______/______

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

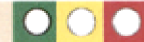
WHAT IS YOUR IMMEDIATE CONCERN? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

#	Question	YES	NO
1.	Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___] ____________	☐	☐
2.	Have you had an unfavorable dental experience? ____________	☐	☐
3.	Have you ever had complications from past dental treatment? ____________	☐	☐
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic? ____________	☐	☐
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted? ____________	☐	☐
6.	Have you had any teeth removed? ____________	☐	☐

GUM AND BONE



#	Question	YES	NO
7.	Do your gums bleed or are they painful when brushing or flossing? ____________	☐	☐
8.	Have you ever been treated for gum disease or been told you have lost bone around your teeth? ____________	☐	☐
9.	Have you ever noticed an unpleasant taste or odor in your mouth? ____________	☐	☐
10.	Is there anyone with a history of periodontal disease in your family? ____________	☐	☐
11.	Have you ever experienced gum recession? ____________	☐	☐
12.	Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ____________	☐	☐
13.	Have you experienced a burning sensation in your mouth? ____________	☐	☐

TOOTH STRUCTURE

#	Question	YES	NO
14.	Have you had any cavities within the past 3 years? ____________	☐	☐
15.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ____________	☐	☐
16.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ____________	☐	☐
17.	Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? ____________	☐	☐
18.	Do you have grooves or notches on your teeth near the gum line? ____________	☐	☐
19.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ____________	☐	☐
20.	Do you frequently get food caught between any teeth? ____________	☐	☐

BITE AND JAW JOINT

#	Question	YES	NO
21.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ____________	☐	☐
22.	Do you feel like your lower jaw is being pushed back when you bite your teeth together? ____________	☐	☐
23.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ____________	☐	☐
24.	Have your teeth changed in the last 5 years, become shorter, thinner or worn? ____________	☐	☐
25.	Are your teeth crowding or developing spaces? ____________	☐	☐
26.	Do you have more than one bite and squeeze to make your teeth fit together? ____________	☐	☐
27.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ____________	☐	☐
28.	Do you clench your teeth in the daytime or make them sore? ____________	☐	☐
29.	Do you have any problems with sleep or wake up with an awareness of your teeth? ____________	☐	☐
30.	Do you wear or have you ever worn a bite appliance? ____________	☐	☐

SMILE CHARACTERISTICS

#	Question	YES	NO
31.	Is there anything about the appearance of your teeth that you would like to change? ____________	☐	☐
32.	Have you ever whitened (bleached) your teeth? ____________	☐	☐
33.	Have you felt uncomfortable or self conscious about the appearance of your teeth? ____________	☐	☐
34	Have you been disappointed with the appearance of previous dental work? ____________	☐	☐

Patient's Signature ____ Date______________

Doctor's Signature ____ Date______________

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, ____date____________do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.