CONFIDENTIAL INFORMATION QUESTIONNAIRE

Patients Name Last, First MI	Date of Birth	Sex SSN(US)
Prefer to be called / Home Phone # / Cell Phone # / Work Phone #		
Patients Address Street APT# City State ZIP/Coastal Code	Email	
Marital Status ☐S ☐M ☐W ☐D ☐UNDER AGE 18 / Patients/ Guardian's Employer	Occupation	
Other family members that are patients here	Who can we thank for referring you to our office?	

EMERGENCY CONTACT INFORMATION

Person we may contact in case of an emergency (other than your family home)

Name	Relationship
Home Phone # / Work Phone # / Cell Phone #	

INSURANCE AND FINANCIAL INFORMATION

Insurance Coverage ☐ Yes ☐ No	Insurance Company Name	Insurance Address	Insurance Phone
Subscriber's Name	Patient's Relationship to Subscriber ☐Self ☐Spouse ☐Dependent	Subscriber's Birthday	SSN
Group/Program Number	Employer	Employer's Address	
Secondary Coverage ☐ Yes ☐ No	Insurance Company Name	Insurance Address	Insurance Phone
Subscriber's Name	Patient's Relationship to Subscriber ☐Self ☐Spouse ☐Dependent	Subscriber's Birthday	SSN
Group/Program Number	Employer	Employer's Address	

ASSIGNMENT & RELEASE

I hereby authorize (1) any available insurance benefits to be paid directly to my dentist, (2) the release of my dental healthcare information for any of my dental healthcare insurance claim, (3) the use of my dental records by my dentist in a professional manner that he/she determines, (4) the making of videotapes, photographs, and x-rays of my dental care treatment (collectively "My images"), and (5) my dentist's use of My images in scientific papers, demonstrations and/or presentations without compensation to me. I agree that to the extent the cost of the dental care provided by my dentist is not covered by insurance, I am obliged to pay him/her such uninsured cost (the "Uninsured Costs") in accordance with his/her payment terms and policies. Finally, I certify that I have read or had read to me the contents of this form and understand the risks and limitations involved with the dental treatment that I am to receive.

Signature- Patient/Guardian	Date
Witness Signature	Date

If the above-named Patient is a minor or unable to pay his/her uninsured costs, the undersigned agrees to guarantee the payment of such uninsured costs to the patient's dentist in accordance with his/her payment terms and policies.

Signature- Guarantor or Patient	Date

MEDICAL HISTORY

Last Name_____ First 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

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

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. Hospitalization for illness or injury	☐	☐
2. An allergic or bad reaction to any of the following:	☐	☐
☐ Aspirin, ibuprofen, acetaminophen, codeine		
☐ Penicillin		
☐ Erythromycin		
☐ Tetracycline		
☐ Sulfa		
☐ Local anesthetic		
☐ Fluoride		
☐ Metals (nickel, gold, silver, _____)		
☐ Latex		
☐ Nuts_____		
☐ Fruit_____		
☐ 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. Orthopedic implant (joint replacement)	☐	☐
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. Pneumonia, emphysema, short breath, sarcoidosis	☐	☐
14. Tuberculosis, measles, chicken pox	☐	☐
15. Asthma	☐	☐
16. Breathing/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 or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia)	☐	☐

	YES	NO
26. Osteoporosis/osteopenia (i.e. taking bisphosphonates)	☐	☐
27. Arthritis	☐	☐
28. Autoimmune disease (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29. Glaucoma	☐	☐
30. Contact lenses	☐	☐
31. Head or neck injures	☐	☐
32. Epilepsy, convulsions (seizures)	☐	☐
33. Neurologic disorders (ADD/ADHD, prion disease)	☐	☐
34. Viral infections and cold sores	☐	☐
35. Any lumps or swelling in the mouth	☐	☐
36. Hives, skin rash, hay fever	☐	☐
37. STI/STD/HPV	☐	☐
38. Hepatitis (type____)	☐	☐
39. HIV/AIDS	☐	☐
40. Tumor, abnormal growth	☐	☐
41. Radiation therapy	☐	☐
42. Chemotherapy, immunosuppressive medication	☐	☐
43. Emotional difficulties	☐	☐
44. Psychiatric treatment	☐	☐
45. Antidepressant medication	☐	☐
46. Alcoholism	☐	☐
47. Recreational drug use	☐	☐

ARE YOU:		
Presently being treated for any other illness	☐	☐
Aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)	☐	☐
Taking medication for weight management	☐	☐
Taking dietary supplements	☐	☐
Often exhausted or fatigued	☐	☐
Experiencing frequent headaches	☐	☐
A smoker, smoked previously or use smokeless tobacco	☐	☐
Considered a touchy/sensitive person	☐	☐
Often unhappy or depressed	☐	☐
Taking birth control pills	☐	☐
Currently pregnant	☐	☐
Diagnosed with a prostate disorder	☐	☐

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

_____

List all medication, supplements, and/or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

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

Patient's Signature (or Guardian if patient is under 18)_____ **Date**_____

Doctor's Signature_____ **Date**_____