# 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 |
|---|---|---|
| | | |

How did you hear about us?

Who referred you? Please list name.

## 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 |
|---|---|
| | |

# DENTAL HISTORY

Last Name_____ First 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 **INDIVIDUALLY** ANSWER **YES** OR **NO** TO THE FOLLOWING:*

| | YES | NO |
|---|---|---|
| **PERSONAL HISTORY** | | |
| 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, and at what age? | ☐ | ☐ |
| 6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? | ☐ | ☐ |
| **GUM AND BONE** | | |
| 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 or painful sensation in your mouth not related to your teeth? | ☐ | ☐ |
| **TOOTH STRUCTURE** | | |
| 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 do you 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** | | |
| 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 try to bite your back teeth together? | ☐ | ☐ |
| 23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? | ☐ | ☐ |
| 24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? | ☐ | ☐ |
| 25. Are your teeth becoming more crooked, crowded, or overlapped? | ☐ | ☐ |
| 26. Are your teeth developing spaces or becoming more loose? | ☐ | ☐ |
| 27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? | ☐ | ☐ |
| 28. Do you place your tongue between your teeth or close your teeth against your tongue? | ☐ | ☐ |
| 29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? | ☐ | ☐ |
| 30. Do you clench or grind your teeth together in the daytime or make them sore? | ☐ | ☐ |
| 31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? | ☐ | ☐ |
| 32. Do you wear or have you ever worn a bite appliance? | ☐ | ☐ |
| **SMILE CHARACTERISTICS** | | |
| 33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? | ☐ | ☐ |
| 34. Have you ever whitened (bleached) your teeth? | ☐ | ☐ |
| 35. Have you felt uncomfortable or self-conscious about the appearance of your teeth? | ☐ | ☐ |
| 36. Have you been disappointed with the appearance of previous dental work? | ☐ | ☐ |

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

**Doctor's Signature**_____ **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**_____

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this 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) _____