PLEASE PRINT

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S LEGAL NAME LAST	FIRST	MI	DATE OF BIRTH	SEX	SOCIAL SECURITY #

PREFERS TO BE CALLED:	HOME #	CELL #

PATIENT'S ADDRESS STREET	APT #	CITY	STATE	ZIP	E-MAIL

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

WORK ADDRESS STREET	CITY	STATE	ZIP	WORK PHONE

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

SPOUSE'S WORK ADDRESS STREET	CITY	STATE	ZIP	WORK PHONE

OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE	WHO CAN WE THANK OR REFRRING YOU TO OUR OFFICE

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 DATE OF BIRTH	SUBSCRIBER'S SSN

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

SECONDARY COVERAGE ☐YES ☐NO	SECONDARY INSURANCE NAME	SECONDARY INSURANCE ADDRESS	SECONDARY 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'S 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 sevices 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 making of videotapes, photographs, and x-rays before, during, and after treatment, and to use the 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____________________

Patient/Guardian

Witness Signature____ Date____________________

PLEASE PRINT

REQUEST FOR CONFIDENTIAL COMMUNICATION

AS MY DENTAL CARE PROVIDER YOU MAY DO THE FOLLOWING WITH MY PERMISSION:

	YES	NO
contact me at home	☐	☐
contact me via cell phone	☐	☐
contact me at work	☐	☐
contact me via e-mail	☐	☐
leave messages on my home voicemail/answering machine	☐	☐
leave messages on my cell phone voicemail	☐	☐
leave messages on my work voicemail/answering machine	☐	☐

EMERGENCY CONTACT INFORMATION

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

NAME RELATIONSHIP

HOME #	WORK #	CELL #

RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTH CARE WITH

	YES	NO
Health Care Providers	☐	☐
Insurance Companies	☐	☐

OTHERS NAME (PLEASE PRINT)

1.

2.

Signature____Date__________________
Patient/Guardian

Witness Signature____________________________________Date__________________

OFFICE USE ONLY

DATE	RS	DATE	RS

DENTAL HISTORY

My previous dentist was ______________________________whom I have been a patient of for ______months/years.
I am satisfied with my past dentist and dentistry. ☐Yes ☐No. The condition of my mouth is ☐Excellent ☐Good ☐Fair ☐Poor.
I visit the dentist every ☐3 mo ☐4 mo ☐6 mo ☐12 mo ☐only when I have a problem.
My most recent exam/cleaning _____/_____/_____ Most recent X rays ____/____/____ ☐Bite Wings ☐Full Mouth ☐Pan.
Date of most recent dental treatment (besides cleaning) _____/_____/_____ Treatment performed __________________
My dental health is a ☐Low ☐Medium ☐High priority to me .

Purpose for today's visit____

YES NO — PERSONAL HISTORY

- ☐ ☐ Are you fearful or nervous about having dental treatment? (circle one) ***Not at all*** 1 2 3 4 5 6 7 8 9 10 ***Very***
- ☐ ☐ Have you had an unfavorable dental experience?
- ☐ ☐ Have you ever had complications from past dental treatment?
- ☐ ☐ Have you ever had trouble getting numb or had any reactions to local anesthetic?
- ☐ ☐ Have you ever had braces, orthodontic treatment or had your bite adjusted?
- ☐ ☐ Have you had any teeth removed (about what year)? ____________

YES NO — AESTHETICS

- ☐ ☐ Is there anything about the appearance of your teeth that you would like to change?
- ☐ ☐ Have you ever whitened (bleached) your teeth?
- ☐ ☐ Have you felt uncomfortable or self conscious about the appearance of your teeth?
- ☐ ☐ Have you been disappointed with the appearance of previous dental work?
- ☐ ☐ Have you ever had lip enhancement surgery or botox injections?

YES NO — BITE

- ☐ ☐ Do you have problems with your jaw joint (pain, popping, clicking, grating, or limited movement)?
- ☐ ☐ Do you/would you have problems chewing certain types of food, i.e. gum, bagels, protein bars, or hard foods?
- ☐ ☐ Have your teeth changed in the last 5 years (become shorter, thinner or worn down)?
- ☐ ☐ Are your teeth crowding or developing spaces?
- ☐ ☐ Do you have more than one bite or have to squeeze to make your teeth fit together?
- ☐ ☐ Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?
- ☐ ☐ Do you clench your teeth in the daytime or do anything to make them sore?
- ☐ ☐ Do you have any problems with sleep or do you wake up with an awareness of your teeth?
- ☐ ☐ Do you wear or have you ever worn a bite appliance?

YES NO — CAVITIES

- ☐ ☐ Have you had any cavities within the past 3 years?
- ☐ ☐ Do you need to sip liquids during meals to help you swallow your food?
- ☐ ☐ Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?
- ☐ ☐ Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?
- ☐ ☐ Do you have grooves or notches on your teeth near the gum line?
- ☐ ☐ Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?
- ☐ ☐ Do you get food caught between any teeth?

YES NO — GUMS

- ☐ ☐ Have you ever been treated for gum disease or been told you have lost bone around your teeth?
- ☐ ☐ Do your gums bleed when brushing or flossing?
- ☐ ☐ Have you ever noticed an unpleasant taste or odor in your mouth?
- ☐ ☐ Is there anyone with a history of periodontal disease in your family?
- ☐ ☐ Have you ever experienced gum recession?
- ☐ ☐ Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?
- ☐ ☐ Have you experienced a burning sensation in your mouth?
- ☐ ☐ Do you brush less than twice a day? I floss once per ☐Day ☐Week ☐Month ☐Year ☐Never

Patient's Signature ____Date_________________

Doctor's Signature ____Date_________________

MEDICAL HISTORY

Patient Name ______________________________ Age __________

Name of Physician and their specialty ______________________________

Most recent physical examination ______________________________ Purpose ______________________________

I believe my general health to be ☐Excellent ☐Good ☐Fair ☐Poor.

YES NO DO YOU HAVE OR HAVE YOU EVER HAD:

☐ ☐ hospitalization for illness or injury
☐ ☐ drug allergies:
- ☐lidocaine or other local anesthetic
- ☐penicillin, sulfa or other antibiotics
- ☐codeine or other pain medications
- ☐other ______________________________

☐ ☐ food allergies:
- ☐egg or soy
- ☐other______________________________

☐ ☐ environmental allergies:
- ☐nickel or other metals
- ☐mosquito, bees or other insects
- ☐latex
- ☐other______________________________

☐ ☐ heart problems, or cardiac stent within the last 6 months
☐ ☐ history of infective endocarditis
☐ ☐ artificial heart valve, repaired heart defect (PFO)
☐ ☐ pacemaker or implantable defibrillator
☐ ☐ artificial prosthesis (heart valve or joints)
☐ ☐ rheumatic or scarlet fever
☐ ☐ high or low blood pressure
☐ ☐ a stroke (or taking blood thinners)
☐ ☐ anemia or other blood disorder
☐ ☐ prolonged bleeding due to a slight cut (INR > 3.5)
☐ ☐ emphysema or sarcoidosis
☐ ☐ tuberculosis
☐ ☐ asthma
☐ ☐ breathing or sleep problems (i.e. sinus, snoring, apnea)
☐ ☐ kidney disease
☐ ☐ liver disease or jaundice
☐ ☐ thyroid, parathyroid disease, or calcium deficiency
☐ ☐ hormone deficiency
☐ ☐ high cholesterol (or taking “statin” drugs)
☐ ☐ diabetes (HbA1c =______ %) (<7% good)
☐ ☐ stomach or duodenal ulcer

YES NO

☐ ☐ digestive disorders (i.e. gastric reflux or G.E.R.D.)
☐ ☐ osteoporosis or osteopenia (i.e. bisphosphonates)
☐ ☐ arthritis
☐ ☐ glaucoma
☐ ☐ contact lenses
☐ ☐ head or neck injuries
☐ ☐ epilepsy or convulsions (seizures)
☐ ☐ neurologic condition (including ADD or ADHD)
☐ ☐ viral infections or cold sores
☐ ☐ lumps or swelling in the mouth
☐ ☐ hives or skin rash
☐ ☐ venereal disease
☐ ☐ hepatitis (type _______)
☐ ☐ HIV or AIDS
☐ ☐ tumor or abnormal growth
☐ ☐ radiation therapy
☐ ☐ chemotherapy
☐ ☐ emotional problems, anxiety, or psychiatric treatment
☐ ☐ antidepressant or anxiety medication
☐ ☐ alcohol or recreational drug dependency
☐ ☐ weight management medications(i.e. fen-phen, redux)

ARE YOU:

☐ ☐ presently being treated for any other illness
☐ ☐ aware of a change in your general health
☐ ☐ taking dietary supplements
☐ ☐ often exhausted or fatigued
☐ ☐ subject to frequent headaches
☐ ☐ a smoker or smoked previously
☐ ☐ considered a touchy person
☐ ☐ often unhappy or depressed
☐ ☐ FEMALE - taking birth control pills
☐ ☐ FEMALE - pregnant
☐ ☐ MALE - prostate disorders

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment

____

____

List all medications, supplements, and or vitamins taken within the last two years (ask for additional sheets if needed)

Drug	Purpose		Drug	Purpose	

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______________

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