

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S NAME		LAST	FIRST	MIDDLE	DATE OF BIRTH	SEX	SOCIAL SECURITY #		
PATIENT'S ADDRESS		STREET	APT#	CITY	STATE	ZIP	EMAIL	HOME PHONE	
MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> UNDER AGE 18		PATIENT'S/GUARDIAN'S EMPLOYER				OCCUPATION			
WORK ADDRESS		STREET	CITY	STATE	ZIP	CELL PHONE	WORK PHONE	OK TO CALL WORK <input type="checkbox"/> YES <input type="checkbox"/> NO	
SPOUSE'S NAME		LAST	FIRST	MIDDLE	SPOUSE'S EMPLOYER		OCCUPATION		
WORK ADDRESS		STREET	CITY	STATE	ZIP	CELL PHONE	WORK PHONE	OK TO CALL WORK <input type="checkbox"/> YES <input type="checkbox"/> NO	
PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)									
NAME		RELATIONSHIP		HOME #	WORK #		CELL #		
OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE				WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE					

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO		INSURANCE COMPANY NAME			ADDRESS		PHONE	
SUBSCRIBER'S NAME		PATIENT'S RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT		SUBSCRIBER'S DATE OF BIRTH		SUBSCRIBER'S SSN		
GROUP/PROGRAM NUMBER		EMPLOYER (IF DIFFERENT FROM ABOVE)			EMPLOYER ADDRESS			
SECONDARY COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO		INSURANCE COMPANY NAME			ADDRESS		PHONE	
SUBSCRIBER'S NAME		PATIENT'S RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> 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 _____

PATIENTS DENTAL HEALTH

Why have you come in to see us today? (e.g.: pain, checkup, etc.) _____

Previous Dentist _____ Last Visit _____ Date of last cleaning _____

Reasons for changing dentists: _____

What problems have you had with past dental treatment? _____

Are you nervous about seeing a dentist? Yes! No If yes, please tell us why: _____

How often do you brush? _____ Do you floss? Yes No How often? _____

(please circle each)

Y N I clench or grind my teeth during the day or while sleeping.	Y N My gums feel tender or swollen
Y N My gums bleed while brushing or flossing.	Y N I have problems eating.
Y N I like my smile.	Y N I have had orthodontics.
Y N I prefer tooth-colored fillings.	Y N I have had a facial or jaw injury.
Y N I avoid brushing part of my mouth due to pain.	Y N I want my teeth straight.
	Y N I want my teeth whiter.

What are your dental priorities? _____
(e.g.: apprentice, dental health, financial considerations, etc.)

PATIENTS MEDICAL HISTORY

I consider my health to be (please check one) Excellent Good Fair Poor

Do you or have you had any of the following? please circle Y for yes or N for no.

1. Y N Heart Disease	22. Y N Liver Disease	Doctor Notes Only:
2. Y N Heart Murmur/Mitral Valve Prolapse	23. Y N Jaundice	
3. Y N Stroke	24. Y N Hepatitis Type _____	
4. Y N Congenital Heart Lesions	25. Y N Diabetes	
5. Y N Rheumatic Fever	26. Y N Excessive Urination and/or Thirst	
6. Y N Abnormal Blood Pressure	27. Y N Infectious Mononucleosis (Mono)	
7. Y N Anemia	28. Y N Herpes	
8. Y N Prolonged Bleeding Disorder	29. Y N Arthritis	
9. Y N Tuberculosis or Lung Disease	30. Y N Sexually Transmitted/Venereal Disease	
10. Y N Asthma	31. Y N Kidney Disease	
11. Y N Hay Fever	32. Y N Tumor or Malignancy	
12. Y N Sinus Trouble	33. Y N Cancer/Chemotherapy	
13. Y N Epilepsy/Seizures	34. Y N Radiation Treatment	
14. Y N Ulcers	35. Y N History of Drug Addiction	
15. Y N Implants/Artificial Joints: <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Other		
16. Y N I smoke or use tobacco. If yes, how much per day? _____ How many years? _____		
17. Y N I have consumed alcohol within the last 24 hours.		
18. Y N I usually take an antibiotic prior to dental treatment.		
19. Y N Have you ever taken Fen-Phen or Redux?		
20. Y N I have had major surgery: Year _____ Type of operation: _____ Year _____ Type of operation: _____		

36. Y N AIDS

37. Y N Immune Suppressed Disorder

38. Y N Hearing Loss

39. Y N Fainting Spells

40. Y N Glaucoma

41. Y N History of Emotional or Nervous Disorders

WOMEN

42. Y N Are you taking birth control medication?

43. Y N Are you or could you be pregnant or nursing?

21. Y N Do you have any other medical problem or medical history NOT listed on this form? _____

<p>Are you allergic to any of the following? Please circle Y for yes or N for no</p> <p>44. Y N Aspirin</p> <p>45. Y N Ibuprofen</p> <p>46. Y N Sulfa Drugs/Sulfites/Sulfides</p> <p>47. Y N Penicillin</p> <p>48. Y N Codeine</p> <p>49. Y N Latex, Metals, Plastics</p> <p>50. Y N Local Anesthetics (Novocaine)</p> <p>51. Y N Other Medications - Which ones? _____</p>	<p>Please list all medications you are currently taking:</p> <p>Medicine _____ Condition _____</p> <p>Medicine _____ Condition _____</p> <p>Medicine _____ Condition _____</p> <p>Medicine _____ Condition _____</p> <p>Physician's Name _____ Phone _____</p> <p>Address _____ Fax _____</p>
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In the event of an emergency please contact:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Initial medical/dental health reviewed by:

X _____ / _____ / _____ X _____ / _____ / _____
Doctor's Signature Date Patient's Signature Date

Periodic medical/dental health reviewed by:

X _____ / _____ / _____ X _____ / _____ / _____
Doctor's Signature Date If patient is a minor, Parent/Guardian's Signature Date

GETTING TO KNOW YOU AS OUR PATIENT