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 ❏ M ❏ S ❏ D ❏ W ❏ UNDER AGE 18	PATIENT'S/GUARDIAN'S EMPLOYER	OCCUPATION

WORK ADDRESS	STREET	CITY	STATE	ZIP	CELL PHONE	WORK PHONE	OK TO CALL WORK ❏ YES ❏ 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 ❏ YES ❏ 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 ❏ 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 ______________

Creating Restorative Excellence *Center For Advanced Dental Learning*
1998 • 1-800-457-9165

MEDICAL HISTORY

Patient Name________________________________ Nickname____________________________ Age __________

Name of Physician____

Date of last physical examination ______________________________ Purpose ______________________________

What is your estimate of your general health? Poor _________ Fair ________ Good ________

HAVE YOU EVER HAD THE FOLLOWING: YES NO

1. hospitalization for illness or injury ❑ ❑
2. allergic reaction to
   - ❑ aspirin, ibuprofen, acetomenophen
   - ❑ penicillin
   - ❑ erythromycin
   - ❑ tetracycline
   - ❑ codeine
   - ❑ local anesthetic
   - ❑ fluoride
   - ❑ metals (gold, stainless steel)
   - ❑ latex
   - ❑ any other medications ____________
3. heart problems ❑ ❑
4. heart murmur ❑ ❑
5. rheumatic fever ❑ ❑
6. scarlet fever ❑ ❑
7. high blood pressure ❑ ❑
8. low blood pressure ❑ ❑
9. a stroke ❑ ❑
10. artificial prosthesis (i.e. heart valve or joints) ❑ ❑
11. anemia or other blood disorder ❑ ❑
12. prolonged bleeding due to a slight cut ❑ ❑
13. emphysema ❑ ❑
14. tuberculosis ❑ ❑
15. asthma ❑ ❑
16. sinus problems ❑ ❑
17. kidney disease ❑ ❑
18. liver disease ❑ ❑
19. jaundice ❑ ❑
20. thyroid or parathyroid disease ❑ ❑
21. hormone deficiency ❑ ❑
22. high cholesterol ❑ ❑
23. diabetes ❑ ❑
24. stomach or duodenal ulcer ❑ ❑
25. digestive disorders ❑ ❑

YES NO

26. arthritis ❑ ❑
27. glaucoma ❑ ❑
28. contact lenses ❑ ❑
29. head or neck injuries ❑ ❑
30. epilepsy, convulsions (seizures) ❑ ❑
31. viral infections and cold sores ❑ ❑
32. any lumps or swelling in the mouth ❑ ❑
33. hives, skin rash, hay fever ❑ ❑
34. venereal disease ❑ ❑
35. hepatitis (type ______) ❑ ❑
36. HIV / AIDS ❑ ❑
37. tumor, abnormal growth ❑ ❑
38. radiation therapy ❑ ❑
39. chemotherapy ❑ ❑
40. emotional problems ❑ ❑
41. psychiatric treatment ❑ ❑
42. antidepressant medication ❑ ❑
43. alcohol / drug dependency ❑ ❑

ARE YOU:

44. presently being treated for any illness ❑ ❑
45. aware of a change in your general health ❑ ❑
46. often exhausted or fatigued ❑ ❑
47. subject to frequent headaches ❑ ❑
48. a heavy smoker (1 pack or more a day) ❑ ❑
49. considered a touchy person ❑ ❑
50. often unhappy or depressed ❑ ❑
51. easily upset or irritated ❑ ❑
52. FEMALE - taking birth control pills ❑ ❑
53. FEMALE - pregnant ❑ ❑
54. MALE - Prostate disorders ❑ ❑

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment____

____

List any medications taken within the last two years____

____

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 Remarks: ____

________________________________ Doctor's Signature________________________________

OVER

DENTAL HISTORY

Referred by ______________________________

Previous dentist ______________________________ How long ______________________________

Last dental exam ______________________________ Last dental x-ray ______________________________

Last dental treatment ______________________________

How often do you have your teeth cleaned? 3 mo._____ 4 mo._____ 6 mo._____ 1 year or longer_____

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? ______________________________

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
1. unhappy with the appearance of your teeth	❑	❑
2. unfavorable dental experiences	❑	❑
3. dental fears	❑	❑
4. problems with effectiveness or bad reactions to dental anesthetic	❑	❑
5. orthodontic treatment (braces) when	❑	❑
6. periodontal (gum) treatment when	❑	❑
7. bleeding gums	❑	❑
8. avoid brushing any part of your mouth	❑	❑
9. part of your mouth is sensitive to temperature	❑	❑
10. sore teeth	❑	❑
11. a burning sensation in your mouth	❑	❑
12. difficulty swallowing	❑	❑
13. an unpleasant taste or odor in your mouth	❑	❑
14. dry mouth	❑	❑
15. jaw problems (temporomandibular joint)	❑	❑
16. difficultly opening your mouth widely	❑	❑
17. stiff neck muscles	❑	❑
18. awaken with an awareness of your teeth or jaws	❑	❑
19. tension headaches	❑	❑
20. clench or grind your teeth	❑	❑
21. jaw clicking or popping	❑	❑
22. lost any teeth	❑	❑
23. do you sweat or tremble a lot during examination	❑	❑
24. do strange people or places make you afraid	❑	❑

SUPPLEMENTAL DENTURE HISTORY:

If you are wearing a partial or complete artificial denture, please complete the following:

YES	NO	(Please check Yes or No)
❑	❑	Has your present denture been relined? When ______________________________
❑	❑	Is your present denture a problem? Describe ______________________________
❑	❑	Satisfied with the appearance? ______________________________
❑	❑	Satisfied with the comfort? ______________________________
❑	❑	Satisfied with the chewing ability? ______________________________
		When did you receive your first partial or complete denture? ______________________________
		How long have you worn your present denture? ______________________________

Patient's Signature ______________________________ Date ______________

Doctor's Remarks: ______________________________

______________________________ Doctor's Signature ______________________________

OVER

Our Financial Policy

Our office wants all of our patients to be able to comfortably afford their dental care. We will do our best to give you an estimate for each upcoming visit based on your individual treatment plan.

We proudly offer the following financial options so that our patients can have the dentistry they would like.

- **Cash**
- **Credit Cards / Debit Cards**
- **Personal Checks and Cashier Checks**
- **Monthly payments with an approved credit account:**
  - **Care Credit - Third party financing**
  - **Citibank - Third party financing**

Insurance:

Our office understands the value of insurance benefits to our clients. It is important to understand, however, that when we provide advice on treatment considerations, it is never based on your insurance coverage. It is always based on what is the best care for you.

As a courtesy to you we will file insurance claims to the companies with whom we participate, on your behalf. We will estimate your deductible and the portion not covered by your insurance. These fees are due at the time of service.

If reimbursement from your insurance is not received within 60 calendar days from the date of treatment, the entire cost of treatment becomes the responsibility of the patient. We will continue to assist you with communication with your carrier.

Delinquent Accounts:

Accounts over 90 days will be referred to a collection agency. All referred accounts will be considered "inactive" and you can only receive continued dental care once the delinquent balance plus a reactivation fee of 50% of the delinquent balance is paid. All future treatment will be cash at the time of treatment.

Returned Checks:

A returned check fee of $25.00 will be added to your account for any returned check.

__________________________________ __________________

Responsible Party Signature Date

Change of Appointment Policy

Our clients are normally seen by appointment. We politely request a 24 hour (week day) advanced notice if an appointment needs to be changed or rescheduled.

We respect the importance of your time and work hard to schedule appointments to accommodate the busy needs of our clients.

In return we ask our clients make every effort to notify us, **with at least** 24 hour advance notice, if an appointment change becomes necessary.

We understand the unforeseen circumstances may arise but we hope you understand that broken and missed appointments:

- interrupt the flow of your treatment to optimum oral health
- are a lost opportunity for others who need care
- and are a contributing factor to rising health care costs

As a courtesy, we make every effort to confirm your appointments, however we trust you to keep your appointments whether we are able to confirm or not.

With this in mind, we respectfully reserve the right to charge for missed or broken appointments without a 24 hour (week day) notice, or if you arrive to your appointment excessively late.

______________________________ ____________

Responsible Party Signature Date

PAUL DARMON D.D.S., P.C.
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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)

____

____

____

© 2002 American Dental Association
All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).