PLEASE PRINT

CONFIDENTIAL INFORMATION QUESTIONNAIRE

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

PREFER TO BE CALLED | HOME PHONE # | CELL PHONE #

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

MARITAL STATUS

☐ S ☐ M ☐ W ☐ D

☐ UNDER AGE 18

PATIENT'S / GUARDIAN'S EMPLOYER | OCCUPATION

WORK ADDRESS STREET APT# CITY STATE ZIP | WORK PHONE #

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

SPOUSE'S WORK ADDRESS STREET APT# CITY STATE ZIP | WORK PHONE #

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 #

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		

PLEASE PRINT

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	SUBSCRIBER'S SSN / ID #

GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	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	SUBSCRIBER'S SSN / ID #

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

RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTHCARE WITH

	YES	NO
Health Care Providers		
Insurance Companies		

OTHERS (PLEASE PRINT)

1.

2.

CONFIRMATIONS

DO YOU PREFER A CONFIRMATION CALL

No, it is unnecessary   Yes, it is a helpful reminder

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 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 - PATIENT / GUARDIAN	DATE
WITNESS SIGNATURE	DATE

MEDICAL HISTORY

Patient 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

DO YOU HAVE or HAVE YOU EVER HAD:

		YES	NO
1.	hospitalization for illness or injury ____________	☐	☐
2.	an allergic reaction to		
	☐ aspirin, ibuprofen, acetaminophen, codeine		
	☐ penicillin		
	☐ erythromycin		
	☐ tetracycline		
	☐ sulfa		
	☐ local anesthetic		
	☐ fluoride		
	☐ metals (nickel, gold, silver, ________)		
	☐ latex		
	☐ 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.	artificial prosthesis (heart valve or joints) ____________	☐	☐
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.	emphysema, sarcoidosis ____________	☐	☐
14.	tuberculosis ____________	☐	☐
15.	asthma ____________	☐	☐
16.	breathing or sleep problems (i.e. 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 disorders (i.e. gastric reflux) ____________	☐	☐
26.	osteoporosis/osteopenia (i.e. taking bisphosphonates) __	☐	☐
27.	arthritis ____________	☐	☐
28.	glaucoma ____________	☐	☐
29.	contact lenses ____________	☐	☐
30.	head or neck injuries ____________	☐	☐
31.	epilepsy, convulsions (seizures) ____________	☐	☐
32.	neurologic problems (attention deficit disorder) ________	☐	☐
33.	viral infections and cold sores ____________	☐	☐
34.	any lumps or swelling in the mouth ____________	☐	☐
35.	hives, skin rash, hay fever ____________	☐	☐
36.	STI / STD ____________	☐	☐
37.	hepatitis (type ___) ____________	☐	☐
38.	HIV / AIDS ____________	☐	☐
39.	tumor, abnormal growth ____________	☐	☐
40.	radiation therapy ____________	☐	☐
41.	chemotherapy ____________	☐	☐
42.	emotional problems ____________	☐	☐
43.	psychiatric treatment ____________	☐	☐
44.	antidepressant medication ____________	☐	☐
45.	alcohol / street drug use ____________	☐	☐

ARE YOU:

		YES	NO
46.	presently being treated for any other illness ________	☐	☐
47.	aware of a change in your health (i.e. fever, new cough) __	☐	☐
48.	taking medication for weight management (i.e. fen-phen)	☐	☐
49.	taking dietary supplements ____________	☐	☐
50.	often exhausted or fatigued ____________	☐	☐
51.	experiencing frequent headaches ____________	☐	☐
52.	a smoker, smoked previously or use smokeless tobacco _	☐	☐
53.	considered a touchy person ____________	☐	☐
54.	often unhappy or depressed ____________	☐	☐
55.	FEMALE - taking birth control pills ____________	☐	☐
56.	FEMALE - pregnant ____________	☐	☐
57.	MALE - prostate disorders ____________	☐	☐

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

____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

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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DENTAL HISTORY

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

PERSONAL HISTORY

		YES	NO
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? ______	☐	☐
6.	Have you had any teeth removed? ______	☐	☐

SMILE CHARACTERISTICS

		YES	NO
7.	Is there anything about the appearance of your teeth that you would like to change? ______	☐	☐
8.	Have you ever whitened (bleached) your teeth? ______	☐	☐
9.	Have you felt uncomfortable or self conscious about the appearance of your teeth? ______	☐	☐
10	Have you been disappointed with the appearance of previous dental work? ______	☐	☐

BITE AND JAW JOINT

		YES	NO
11.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ______	☐	☐
12.	Do you / would you have any problems chewing gum? ______	☐	☐
13.	Do you / would you have any problems chewing bagels, baguettes , protein bars, or other hard foods? ______	☐	☐
14.	Have your teeth changed in the last 5 years, become shorter, thinner or worn? ______	☐	☐
15.	Are your teeth crowding or developing spaces? ______	☐	☐
16.	Do you have more than one bite and squeeze to make your teeth fit together? ______	☐	☐
17.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ______	☐	☐
18.	Do you clench your teeth in the daytime or make them sore? ______	☐	☐
19.	Do you have any problems with sleep or wake up with an awareness of your teeth? ______	☐	☐
20.	Do you wear or have you ever worn a bite appliance? ______	☐	☐

TOOTH STRUCTURE

		YES	NO
21.	Have you had any cavities within the past 3 years? ______	☐	☐
22.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ______	☐	☐
23.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ______	☐	☐
24.	Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? ______	☐	☐
25.	Do you have grooves or notches on your teeth near the gum line? ______	☐	☐
26.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ______	☐	☐
27.	Do you frequently get food caught between any teeth? ______	☐	☐

GUM AND BONE

		YES	NO
28.	Do your gums bleed or are they painful when brushing or flossing? ______	☐	☐
29.	Have you ever been treated for gum disease or been told you have lost bone around your teeth? ______	☐	☐
30.	Have you ever noticed an unpleasant taste or odor in your mouth? ______	☐	☐
31.	Is there anyone with a history of periodontal disease in your family? ______	☐	☐
32.	Have you ever experienced gum recession? ______	☐	☐
33.	Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ______	☐	☐
34.	Have you experienced a burning sensation in your mouth? ______	☐	☐

Patient's Signature ____ Date____________________

Doctor's Signature ____ Date ____________________

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