

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		PATIENT'S / GUARDIAN'S EMPLOYER				OCCUPATION	
<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> UNDER AGE 18							
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		

INSURANCE AND FINANCIAL INFORMATION

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

RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTHCARE WITH

	YES	NO	OTHERS (PLEASE PRINT)
Health Care Providers			1.
Insurance Companies			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			YES	NO
1.	hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	26.	osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	<input type="checkbox"/>	<input type="checkbox"/>
2.	an allergic reaction to			27.	arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine			28.	glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> penicillin			29.	contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> erythromycin			30.	head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> tetracycline			31.	epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> sulfa			32.	neurologic problems (attention deficit disorder) _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> local anesthetic			33.	viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> fluoride			34.	any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> metals (nickel, gold, silver, _____)			35.	hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> latex			36.	venereal disease _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> other _____			37.	hepatitis (type _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
3.	heart problems, or cardiac stent within the last six months _____	<input type="checkbox"/>	<input type="checkbox"/>	38.	HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
4.	history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	39.	tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
5.	artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	40.	radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
6.	pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	41.	chemotherapy _____	<input type="checkbox"/>	<input type="checkbox"/>
7.	artificial prosthesis (heart valve or joints) _____	<input type="checkbox"/>	<input type="checkbox"/>	42.	emotional problems _____	<input type="checkbox"/>	<input type="checkbox"/>
8.	rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	43.	psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
9.	high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	44.	antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
10.	a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>	45.	alcohol / street drug use _____	<input type="checkbox"/>	<input type="checkbox"/>
11.	anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>				
12.	prolonged bleeding due to a slight cut (INR > 3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:			
13.	emphysema, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>	46.	presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
14.	tuberculosis _____	<input type="checkbox"/>	<input type="checkbox"/>	47.	aware of a change in your health (i.e. fever, new cough) _____	<input type="checkbox"/>	<input type="checkbox"/>
15.	asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	48.	taking medication for weight management (i.e. fen-phen) _____	<input type="checkbox"/>	<input type="checkbox"/>
16.	breathing or sleep problems (i.e. snoring, sinus) _____	<input type="checkbox"/>	<input type="checkbox"/>	49.	taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
17.	kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	50.	often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
18.	liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	51.	experiencing frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
19.	jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	52.	a smoker, smoked previously or use smokeless tobacco _____	<input type="checkbox"/>	<input type="checkbox"/>
20.	thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	53.	considered a touchy person _____	<input type="checkbox"/>	<input type="checkbox"/>
21.	hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	54.	often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
22.	high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	55.	FEMALE - taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
23.	diabetes (HbA1c = _____) _____	<input type="checkbox"/>	<input type="checkbox"/>	56.	FEMALE - pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
24.	stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>	57.	MALE - prostate disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
25.	digestive disorders (i.e. gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>				

Describe any current medical treatment, impending surgery, 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 _____



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



1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ YES NO
2. Have you had an unfavorable dental experience? _____ YES NO
3. Have you ever had complications from past dental treatment? _____ YES NO
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ YES NO
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ YES NO
6. Have you had any teeth removed? _____ YES NO

SMILE CHARACTERISTICS



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

BITE AND JAW JOINT



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

TOOTH STRUCTURE



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

GUM AND BONE



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

Patient's Signature _____ Date _____

Doctor's 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

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's Checks
- Monthly payments with an approved credit account- Care Credit

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 on your behalf. We will estimate your deductible and the portion not covered by your insurance. Please understand that these are ESTIMATES and NOT a guarantee of payment from your insurance company.

After all reasonable efforts have been exhausted on our part to collect from your insurance company, usually within 60 business days from the date of treatment, the entire cost of the treatment becomes the responsibility of the patient. We will continue to assist you with communication with your carrier as necessary.

Delinquent Accounts:

Accounts over 120 days without a good faith intent to resolve balance will be referred to a third party collection agency. All referred accounts will be considered no longer in good standing and patients will be dismissed from our practice.

Returned Checks:

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

Responsible Party Signature

Date

Paul Darmon, DDS, PC * 31815 Southfield Rd., Suite 20 * Beverly Hills, MI 48025 * (248)645-8800

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)

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