PLEASE PRINT

**Today’s Date:**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CONFIDENTIAL INFORMATION QUESTIONNAIRE** | | | | | | | | | | |
| **Patient’s Legal name Last First Middle Initial** | | | | | | | **Date OF Birth** | **Sex** | **SSN** | |
| **Prefer to Be Called** | | | | **Home Phone Number** | | | | **Cell Phone Number** | | |
| **Patient’s Address** | | **Street** | **Apt#** | | **City** | **State/Zip** | | **E-mail** | | |
| **Marital Status** | **Patient’s/Guardian’s Employer** | | | | | | | **Occupation** | | |
|  **S**  **M**  **W**  **D**   **Under age 18** |
| **Work Address** | | **Street** | **Apt#** | | **City** | **State/Zip** | | **Work Phone Number** | | |
| **Spouse’s Legal Name** | | **Last** | **First** | | **MI** |  | **Spouse’s Employer** | | | **Occupation** |
| **Spouse’s Work Address** | | **Street** | **Apt#** | | **City** | **State/Zip** | | **Work Phone Number** | | |
| **Other Family Members that are Patients Here** | | | | | | | **Who can we thank for referring you to our office?** | | | |
| **Person we may contact in case of an emergency:** | | | | | | | | | | |
| **Name** | | | | | | | | **Relationship** | | |
| **Home Phone Number** | | | | **Work Phone Number** | | | | **Cell Phone Number** | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **INSURANCE AND FINANCIAL INFORMATION** | | | | | |
| **Insurance Coverage** | **Insurance Company Name** | | **Insurance Address** | | **Insurance Phone** |
|  **Yes**  **No** |
| **Subscriber’s Name** | | **Patient’s Relationship to Subscriber** | | **Subscriber’s Birthday** | **Subscriber’s SSN** |
|  **Self**  **Spouse**  **Dependent** | |
| **Group/Program Number** | | **Employer** | | **Subscribers ID:** | |
| **Secondary Coverage** | **Patient’s/Guardian’s Employer** | | | **Insurance Phone** | |
|  **Yes**  **No** |
| **Subscriber’s name** | | **Patient’s Relationship to Subscriber** | | **Subscriber’s Birthday** | **Subscriber’s SSN** |
|  **Self**  **Spouse**  **Dependent** | |
| **Group/Program Number** | | **Insurance Address:** | | **Subscribers ID:** | |

# 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: (Please circle) 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

1. heart problems, or cardiac stent within the last six months .......  
2. history of infective endocarditis .....................................................  
3. artificial heart valve, repaired heart defect (PFO) .......................  
4. pacemaker or implantable defibrillator ........................................  
5. orthopedic implant (joint replacement) ........................................  
6. rheumatic or scarlet fever ...............................................................  
7. high or low blood pressure ............................................................  
8. a stroke (taking blood thinners) ....................................................  
9. anemia or other blood disorder ....................................................  
10. prolonged bleeding due to a slight cut (INR > 3.5) ...................  
11. emphysema, shortness of breath, sarcoidosis, tuberculosis........  
12. measles, chicken pox…………………………………………..  
13. asthma ...............................................................................................  
14. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)....  
15. kidney disease ..................................................................................  
16. liver disease ......................................................................................  
17. jaundice ............................................................................................  
18. thyroid, parathyroid disease, or calcium deficiency ...................  
19. hormone deficiency .........................................................................  
20. high cholesterol or taking statin drugs ..........................................  
21. diabetes (HbA1c = ) .................................... .  
22. stomach or duodenal ulcer .............................................................  
23. digestive disorders (i.e. celiac disease, gastric reflux) ................  

### YES NO

1. osteoporosis/osteopenia (i.e. taking bisphosphonates) ..............  
2. arthritis ................................................................................................  
3. autoimmune disease (i.e.rheumatoid arthritis, lupus, scleroderma)  
4. glaucoma ...........................................................................................  
5. contact lenses ....................................................................................  
6. head or neck injuries ........................................................................  
7. epilepsy, convulsions (seizures) ......................................................  
8. neurologic disorders (ADD/ADHD, prion disease) ..................  
9. viral infections and cold sores ........................................................  
10. any lumps or swelling in the mouth ..............................................  
11. hives, skin rash, hay fever ...............................................................  
12. STI / STD / HPV ...........................................................................  
13. hepatitis (type ) ...............................................  
14. HIV / AIDS ....................................................................................  
15. tumor, abnormal growth ................................................................  
16. radiation therapy ..............................................................................  
17. chemotherapy, immunosuppressive medication .........................  
18. emotional difficulties .......................................................................  
19. psychiatric treatment.........................................................................  
20. antidepressant medication ..............................................................  
21. alcohol / recreational drug use ......................................................  
22. prostate disorders .............................................................................  

### ARE YOU:

1. presently being treated for any other illness ...............................  
2. aware of a change in your health in the last 24 hours ................  

(i.e. fever, chills, new cough, or diarrhea)

1. taking medication for weight management ................................  
2. taking dietary supplements ............................................................  
3. often exhausted or fatigued ..........................................................  
4. experiencing frequent headaches .................................................  
5. a smoker, smoked previously or use smokeless tobacco...........  
6. considered a touchy / sensitive person .......................................  
7. often unhappy or depressed ..........................................................  
8. taking birth control pills ................................................................  
9. currently pregnant ..........................................................................  

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**

**PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING**

# Dental History

Patient 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 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?

## 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 or missing teeth that never developed? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  

## GUM AND BONE

1. Do your gums bleed or are they painful when brushing or flossing? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  
2. Have you ever been treated for gum disease or been told that you have bone loss around your teeth? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  
3. Have you ever noticed an unpleasant taste or odor in your mouth?. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  
4. Is there anyone with a history of periodontal disease in your family?. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  
5. Have you ever experienced gum recession? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  
6. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? . . . . . . . . . . . . . . .  
7. Have you experienced a burning or painful sensation in your mouth not related to your teeth? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  

## TOOTH STRUCTURE

1. Have you had any cavities within the past 3 years? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  
2. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?
3. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  
4. Are any teeth sensitive to hot, cold, biting, or sweets? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  
5. Do you have grooves or notches on your teeth near the gum line? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  
6. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  
7. Do you frequently get food caught between any teeth? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  

## BITE AND JAW JOINT

1. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  
2. Do you feel like your lower jaw is being pushed back when you bite your teeth together?. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  
3. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? . . . . . . . . . . . . . . ..  
4. Have your teeth changed in the last 5 years, become shorter, thinner or worn? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  
5. Are your teeth becoming more crooked, crowded, or overlapped?. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  
6. Are your teeth developing spaces or becoming more loose? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  
7. Do you need to bite, squeeze, or shift your jaw to make your teeth fit together? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  
8. Do you place your tongue between your teeth or close your teeth against your tongue? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  
9. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  
10. Do you clench your teeth in the daytime or make them sore? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  
11. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? . . . . . . . . . . . . . . . . . . . .  
12. Do you wear or have you ever worn a bite appliance? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  

## SMILE CHARACTERISTICS

1. Is there anything about the appearance of your teeth that you would like to change? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  
2. Have you ever whitened (bleached) your teeth? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  
3. Have you felt uncomfortable or self conscious about the appearance of your teeth? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  
4. Have you been disappointed with the appearance of previous dental work? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  

# TREATMENT CONSENT FORM

I, , consent to be a patient at the above named office and agree to a radiographic and clinical examination. I also understand and consent to the following:

* 1. During the course of treatment, I could possibly undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.
  2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.
  3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.
  4. I will pay in full any cost of treatment or insurance copayments according to the office’s financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been preapproved, I am responsible for any costs that my insurance does not cover.
  5. My treatment plan may change at any time due to unforeseen circumstances and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.
  6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

Patient/Guardian Signature: Date:

# PAYMENT POLICY AGREEMENT

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we ask that you read and sign prior to any treatment. We accept Cash, Checks, Visa, MasterCard, Discover & American Express Cards.

For those patients who DO NOT HAVE DENTAL INSURANCE, payment in full is expected for services rendered on the day of service.

## INSURANCE

If the patient or responsible party has an Insurance plan, the office will produce and send claims to the insurance carrier the same day of service, provided evidence of benefits (Insurance Card/Completed and Signed Form) is presented to the office. **ANY ESTIMATED PORTION OF SERVICES NOT COVERED BY INSURANCE IS DUE ON THE DAY SERVICES ARE RENDERED.**

Your Insurance Policy is a contract between you and your insurance company. We file your insurance and accept assignment of benefits as a courtesy to you, our valued patient. If your insurance company has not paid for your claim within 60 days, you are responsible for payment of the balance at that time. We will be happy to provide necessary documentation to your insurance company so that you may call them to discuss the non-payment of your claim, but we require payment from you for the account balance.

Our Practice is committed to providing the BEST TREATMENT for our patients, and our fees are reasonable for our area. You are responsible for payment regardless of any insurance company’s arbitrary determination of “Usual and Customary” rates or for alternate treatment substitute determination. “Usual and Customary” fees vary widely between different Insurance Plans.

## MISSED APPOINTMENTS

In order to ensure we have appointments available for our patients we must have 2-business days notice if you must cancel a scheduled appointment. *Repeated missed appointments without notice will result in dismissal from our practice.* Please help us serve you better by keeping scheduled appointments.

Patient/Guardian Signature

or Responsible Party Date:

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, have received/been

**Print Name**

offered a copy of this office’s Notice of Privacy Practices.

Patient Signature/Guardian:

Guardian Name (print):

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

 Communication barriers prohibited obtaining the acknowledgement

 An emergency situation prevented us from obtaining acknowledgement

 Other

# AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient: Date of Birth:

The office of Drs. Mann, Scott, & Kuyk is authorized to release protected health information about the above named patient to the entities named below.

|  |  |
| --- | --- |
| **Entity to Receive Information** Check each person/entity that may receive information. | **Description of Information to be Released**  Check each that can be given to person/entity on the left in the same section. |
|  Voice Mail |  Results of lab tests/x-rays   Other: |
|  Spouse (provide name) |  Financial   Medical as follows: |
|  Parent (provide name) |  Financial   Medical as follows: |
|  Insurance |  Healthcare provider   Insurance claims |
|  Other (provide name) |  Financial   Medical as follows: |

**PATIENT INFORMATION:**

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.

I understand that the information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by patient.

Patient/Guardian Signature Date: