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*
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DENTAL HISTORY

Referred by ______________________

Previous dentist ______________________ How long ______________________

Most recent dental exam ______________________ Most Recent dental x-ray ______________________

Most recent 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, throat, and or eyes	❑	❑
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 ______________________

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MEDICAL HISTORY

Patient Name________________________________ Nickname__________________________ Age ___________

Name of Physician____

Most recent 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, herbal supplements, and or vitamins 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______________________________

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Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

Please sign this form below under the heading "acknowledgement" to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

______________________________ ______________________________
Patient Signature Patient Name (please print)

Date: ______________________________

For office use only

Patient Refused to Sign

The following circumstances prohibited the patient from signing the Acknowledgment:

____

An emergency situation prevented the patient from signing the Acknowledgement.

______________________________ ______________________________
Office Personnel (signature) Office Personnel (print name)

Date: ______________________________

Patient Consent

Please sign this form below under the heading "Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

______________________________ ______________________________
Patient Signature Patient Name (please print)

Date: ______________________________