

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	<input type="checkbox"/>	<input type="checkbox"/>
Contact me via cell phone	<input type="checkbox"/>	<input type="checkbox"/>
Contact me at work	<input type="checkbox"/>	<input type="checkbox"/>
Contact me via e-mail	<input type="checkbox"/>	<input type="checkbox"/>
Leave messages on my home voicemail / answering machine	<input type="checkbox"/>	<input type="checkbox"/>
Leave messages on my cell phone voicemail	<input type="checkbox"/>	<input type="checkbox"/>
Leave messages on my work voicemail / answering machine	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	1.
Insurance Companies	<input type="checkbox"/>	<input type="checkbox"/>	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, demonstrations and/or presentations.

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

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) [____] _____
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? _____

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? _____
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____
10. Is there anyone with a history of periodontal disease in your family? _____
11. Have you ever experienced gum recession? _____
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____
13. Have you experienced a burning sensation in your mouth? _____

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? _____
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____
18. Do you have grooves or notches on your teeth near the gum line? _____
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____
20. Do you frequently get food caught between any teeth? _____

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____
25. Are your teeth becoming more crooked, crowded, or overlapped? _____
26. Are your teeth developing spaces or becoming more loose? _____
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____
28. Do you place your tongue between your teeth or rest your teeth against your tongue? _____
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____
30. Do you clench your teeth in the daytime or make them sore? _____
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? _____
32. Do you wear or have you ever worn a bite appliance? _____

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change? _____
34. Have you ever whitened (bleached) your teeth? _____
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____
36. Have you been disappointed with the appearance of previous dental work? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Northside Family Dentistry

Notice of Privacy Practices

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health insurance. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time to obtain a current copy of this notice. I understand that I may request in writing that you restrict how my private information is used or obtained.

_____ (Please Initial)

Payment Policy

Payment for today's visit is due at time of service. You may take advantage of a prepayment reduction for future visits by paying in full at time of scheduling. For those who enjoy dental insurance benefits, we will gladly file your primary dental insurance and have them reimburse you directly.

_____ (Please Initial)

Insurance Policy

We are happy to file the necessary forms to see that you receive full benefits of your coverage. However, insurance companies only pay the assigned percentages on what they feel like service should cost, not necessarily what we charge. Due to this, you may be charged the difference between our fee and what your insurance will pay. Claims are paid according to usual, customary and reasonable fees which varies per insurance company. Your dental insurance is a contract between you, your employer and the insurance company. Northside Family Dentistry is in no way involved in this contract.

_____ (Please Initial)

Confirmation and Cancellation Policy

In order to see or treat our patients to the best of our ability we **require a confirmation 24 hours prior** to your appointment. You must give our office **48 hour notice** to change or cancel an appointment

_____ (Please Initial)

Thank you for choosing Northside Family Dentistry for your dental needs. Our mission is to deliver the finest dental care available today. Our team strives to provide the best service possible. It is important that our patients understand our office policies and work with us to exceed our expectations.