New Patient Confidential Questionnaire

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IMPLANT, ESTHETIC, & RECONSTRUCTIVE DENTISTRY

SO THAT WE MAY TREAT YOU SAFELY AND EFFECTIVELY, PLEASE ANSWER ALL QUESTIONS FULLY. THANK YOU.

PATIENT NAME: _____ AGE: _____ DOB: ___/___/___

MEDICAL HISTORY

When was your last physical exam? _____ Reason for exam? _____

Are you seeing a physician at this time? ☐ YES ☐ NO If so, for what? _____

Physician's Name: _____ Party to notify in case of emergency: _____

Please list any medications (prescription or non-prescription) you are taking, and what they are for:

Are you allergic, or do you react to anything (drugs, food, etc.)? ☐ YES ☐ NO If so, for what?

Do you now, or have you ever had: (check if yes)

- ☐ ARTHRITIS
- ☐ DIABETES
- ☐ THYROID PROBLEM
- ☐ ASTHMA
- ☐ TUBERCULOSIS
- ☐ HEART PROBLEMS/MURMUR
- ☐ RHEUMATIC FEVER
- ☐ HEART VALVE PROBLEMS
- ☐ RHEUMATIC FEVER
- ☐ PACEMAKER
- ☐ HIGH BLOOD PRESSURE
- ☐ IS THERE ANY CHANCE YOU MAY BE PREGNANT?
- ☐ PAIN IN CHEST ON EXERTION
- ☐ SWOLLEN ANKLES
- ☐ ABNORMAL BLEEDING
- ☐ ANEMIA
- ☐ BLOOD TRANSFUSION
- ☐ FATIGUE EASILY
- ☐ BLOOD TRANSFUSION
- ☐ JAUNDICE
- ☐ HEPATITIS
- ☐ LIVER DISEASE
- ☐ CONTACT WITH AIDS VIRUS
- ☐ NERVOUS DISORDER/ PSYCHIATRIC CARE
- ☐ VENEREAL DISEASE
- ☐ EPILEPSY
- ☐ FAINTING SPELLS
- ☐ LATEX ALLERGY
- ☐ MALIGNANCY OR TUMOR
- ☐ RADIATION THERAPY
- ☐ ARTIFICIAL JOINT
- ☐ HISTORY OF DRUG OR ALCOHOL ABUSE
- ☐ DO YOU SMOKE? HOW MUCH? _____ /DAY

DENTAL HISTORY

What is your main reason for problem / coming to SRK? _____

Who referred you to SRK? _____ Any concerns about dental treatment? ☐ YES ☐ NO

How do you feel about the condition of your teeth? _____

How do you feel about your past dental experiences? _____

Do you now, or have you ever had: (check if yes)

- ☐ CLICKING OR POPPING IN JAW JOINT
- ☐ CLENCHING OR GRINDING, DAY OR NIGHT
- ☐ PAINS IN OR NEAR THE EAR
- ☐ "TMJ" SPLINT, OR OTHER TYPES OF TREATMENT
- ☐ OTHER SORE OR PAINFUL AREAS IN YOUR MOUTH
- ☐ REGULAR DENTAL CHECKUPS
- ☐ ANY MISSING TEETH
- ☐ TOOTHACHES
- ☐ BAD BREATH
- ☐ PAIN IN CHEWING
- ☐ CANKER SORES
- ☐ BRIDGEWORK OR PARTIAL DENTURES
- ☐ ORTHODONTIC TREATMENT (BRACES)
- ☐ ROOT CANAL WORK
- ☐ GUM SURGERY, OR NON-SURGICAL TREATMENT (ROOT PLANNING)

When was your last dental visit? _____ Did you have x-rays at that time? ☐ YES ☐ NO

Have you been instructed on how to brush and floss? ☐ YES ☐ NO If so, by whom? _____

How often do you brush? _____ Times per day / week When usually? _____ Type of brush: ☐ HARD ☐ SOFT

What kind of toothpaste? ____ Times per day / week Do you use dental floss? ☐ YES ☐ NO ☐ OCCASIONALLY

DIETARY HISTORY

Do you eat or drink between meals during the day? ☐ YES ☐ NO In the evening? ☐ YES ☐ NO

Does your diet include: (check if yes)

☐ CHEWING GUM ☐ COOKIES/PASTRY ☐ CANDY BARS ☐ HARD CANDY ☐ LIFESAVERS
☐ SOFT DRINKS, SODA, FRUIT JUICE ☐ BREATH MINTS/COUGH DROPS ☐ SUGAR IN COFFEE/TEA

TODAYS DATE: ____/____/____ SIGNATURE: _____

OFFICE USE ONLY

UPDATE: ____/____/____ INITIALS: ____ UPDATE: ____/____/____ INITIALS: ____ UPDATE: ____/____/____ INITIALS: ____ UPDATE: ____/____/____ INITIALS: ____

Patient Info, Insurance & Consent Form

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PATIENT INFORMATION

PATIENT FIRST NAME: _____ LAST: _____ MI: _____

GENDER: ☐ MALE ☐ FEMALE STATUS: ☐ SINGLE ☐ MARRIED ☐ CHILD ☐ OTHER

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ CELL: _____ WORK: _____ EMAIL: _____

RESPONSIBLE PARTY INFORMATION

FIRST NAME: _____ LAST: _____ MI: _____ SS#: _____

RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER

ADDRESS IF DIFFERENT FROM PATIENT: _____ CITY: _____ STATE: _____ ZIP: _____

EMPLOYER NAME: _____ OCCUPATION: _____

INSURANCE INFORMATION - PRIMARY

Please inform us if there is a secondary insurance plan in addition to your primary insurance plan.

FIRST NAME: _____ LAST: _____ MI: _____ DOB: ___/___/___

ID#: _____ GROUP#: _____ IS INSURED A PATIENT?: ☐ YES ☐ NO

INSURED'S ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURED'S EMPLOYER NAME: _____ PLAN NAME: _____ PHONE: _____

REFERRAL INFORMATION

WHOM MAY WE THANK FOR REFERRING TO OUR OFFICE? ☐ DENTAL OFFICE ☐ WEBSITE ☐ INTERNET ☐ PATIENT ☐ RELATIVE

NAME OF PERSON OR OFFICE REFERRING YOU TO OUR PRACTICE: _____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (12% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND AGREE TO THEIR CONTENT.

SIGNATURE: _____ RELATIONSHIP TO PATIENT: _____ DATE: ___/___/___