PLEASE PRINT

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
☐ S ☐ M ☐ W ☐ D ☐ 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	☐	☐

PLEASE PRINT

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE ☐ YES ☐ NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S BIRTHDAY	SUBSCRIBER'S SSN / ID #
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS	

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

RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTHCARE WITH

	YES	NO
Health Care Providers	☐	☐
Insurance Companies	☐	☐

OTHERS (PLEASE PRINT)

1.

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

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

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

YES NO

27. arthritis ____________
28. autoimmune disease ____________
    (i.e. rheumatoid arthritis, lupus, scleroderma)
29. glaucoma ____________
30. contact lenses ____________
31. head or neck injuries ____________
32. epilepsy, convulsions (seizures) ____________
33. neurologic disorders (ADD/ADHD, prion disease) ____________
34. viral infections and cold sores ____________
35. any lumps or swelling in the mouth ____________
36. hives, skin rash, hay fever ____________
37. STI / STD / HPV ____________
38. hepatitis (type ___) ____________
39. HIV / AIDS ____________
40. tumor, abnormal growth ____________
41. radiation therapy ____________
42. chemotherapy, immunosuppressive medication ____________
43. emotional difficulties ____________
44. psychiatric treatment ____________
45. antidepressant medication ____________
46. alcohol / recreational drug use ____________

ARE YOU:

47. presently being treated for any other illness ____________
48. aware of a change in your health in the last 24 hours
    (i.e. fever, chills, new cough, or diarrhea) ____________
49. taking medication for weight management ____________
50. taking dietary supplements ____________
51. often exhausted or fatigued ____________
52. experiencing frequent headaches ____________
53. a smoker, smoked previously or use smokeless tobacco _
54. considered a touchy / sensitive person ____________
55. often unhappy or depressed ____________
56. taking birth control pills ____________
57. currently pregnant ____________
58. prostate disorders ____________

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.

Patient's Signature ______________________ Date ____________
Doctor's Signature ______________________ Date ____________

ASA ______ (1-6)

© 2014 Kois Center, LLC

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 or missing teeth that never developed? ______________

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 or painful sensation in your mouth not related to your teeth? ______________

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 close 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 ______________________

© 2014 Kois Center, LLC