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 ☐ S ☐ M ☐ W ☐ D ☐ UNDER AGE 18	PATIENT'S / GUARDIAN'S EMPLOYER	OCCUPATION

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 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 - PATIENT / GUARDIAN	DATE

WITNESS SIGNATURE	DATE

DENTAL HISTORY

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?	☐	☐
SMILE CHARACTERISTICS		
7. Is there anything about the appearance of your teeth that you would like to change?	☐	☐
8. Have you ever whitened (bleached) your teeth?	☐	☐
9. Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
10 Have you been disappointed with the appearance of previous dental work?	☐	☐
BITE AND JAW JOINT		
11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
12. Do you / would you have any problems chewing gum?	☐	☐
13. Do you / would you have any problems chewing bagels, baguettes , protein bars, or other hard foods?	☐	☐
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐
15. Are your teeth crowding or developing spaces?	☐	☐
16. Do you have more than one bite and squeeze to make your teeth fit together?	☐	☐
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
18. Do you clench your teeth in the daytime or make them sore?	☐	☐
19. Do you have any problems with sleep or wake up with an awareness of your teeth?	☐	☐
20. Do you wear or have you ever worn a bite appliance?	☐	☐
TOOTH STRUCTURE		
21. Have you had any cavities within the past 3 years?	☐	☐
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?	☐	☐
25. Do you have grooves or notches on your teeth near the gum line?	☐	☐
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
27. Do you get food caught between any teeth?	☐	☐
GUM AND BONE		
28. Do your gums bleed when brushing or flossing?	☐	☐
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
30. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
31. Is there anyone with a history of periodontal disease in your family?	☐	☐
32. Have you ever experienced gum recession?	☐	☐
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
34. Have you experienced a burning sensation in your mouth?	☐	☐

Patient's Signature _____ Date _____

Doctor's 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		
☐ sulpha		
☐ 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. artificial prosthesis (heart valve or joints) _____	☐	☐
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, sarcoidosis _____	☐	☐
14. tuberculosis _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. 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. gastric reflux) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	☐	☐
27. arthritis _____	☐	☐
28. glaucoma _____	☐	☐
29. contact lenses _____	☐	☐
30. head or neck injuries _____	☐	☐
31. epilepsy, convulsions (seizures) _____	☐	☐
32. neurologic problems (attention deficit disorder) _____	☐	☐
33. viral infections and cold sores _____	☐	☐
34. any lumps or swelling in the mouth _____	☐	☐
35. hives, skin rash, hay fever _____	☐	☐
36. venereal disease _____	☐	☐
37. hepatitis (type ___) _____	☐	☐
38. HIV / AIDS _____	☐	☐
39. tumor, abnormal growth _____	☐	☐
40. radiation therapy _____	☐	☐
41. chemotherapy _____	☐	☐
42. emotional problems _____	☐	☐
43. psychiatric treatment _____	☐	☐
44. antidepressant medication _____	☐	☐
45. alcohol / drug dependency _____	☐	☐
ARE YOU:		
46. presently being treated for any other illness _____	☐	☐
47. aware of a change in your general health _____	☐	☐
48. taking medication for weight management (i.e. fen-phen)	☐	☐
49. taking dietary supplements _____	☐	☐
50. often exhausted or fatigued _____	☐	☐
51. subject to frequent headaches _____	☐	☐
52. a smoker or smoked previously _____	☐	☐
53. considered a touchy person _____	☐	☐
54. often unhappy or depressed _____	☐	☐
55. FEMALE - taking birth control pills _____	☐	☐
56. FEMALE - pregnant _____	☐	☐
57. MALE - prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

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 _____

NOTICE OF PRIVACY PRACTICES AND DENTAL MATERIALS FACT SHEET

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that healthcare providers give each patient a copy of the provider's Notice of Privacy Practices, and then make a good-faith effort to obtain an acknowledgement of receipt for the notice. Patients may refuse to sign for receipt.

By signing this form, I confirm that I have received a copy of the Dental Office's Notice of Privacy Practices and a copy of the Dental Materials Fact Sheet.

Patient or Parent/Guardian Printed Name _____

Patient or Parent/Guardian Signature _____ Date : _____

Office Use

Written acknowledgement was not obtained because:

- ☐ Patient refused to sign
- ☐ Unable to communicate with patient
- ☐ Emergency situation _____
- ☐ Other _____

YOU SMILE DENTAL GENERAL DENTISTRY INFORMED CONSENT

PATIENT NAME _____ DATE: _____ INITIALS

1. TREATMENT TO BE DONE

I understand that I will be receiving an examination that includes a sufficient number of dental x-rays that may be necessary to complete my examination and any additional community appropriate diagnostic procedures that may be necessary to complete my dental examination and treatment plan. I also understand that if there was a need for a referral to a specialist deemed necessary by my Dentist then the cost of this referral would be my responsibility.

2. DRUGS AND MEDICATIONS

I understand that antibiotics, analgesics and other medication can cause allergic reactions Manifesting clinical symptoms such as (redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock severe allergy reaction) I understand that it is my responsibility to inform my dentist of any allergy to specific medication to avoid possible adverse effects from medication that my dentist will prescribe.

LOCAL ANESTHETICS: The local anesthetic I am receiving may contain epinephrine that can cause slight increase in the heart rate but will return to normal. Common complications that can occur from local anesthetic but are not limited to are pain, swelling, and bruising. Rare serious complications may occur that can include but are not limited to permanent numbness, abnormal sensation, transient blindness, and even death.

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures due to condition found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary once I have been informed of these changes and consented to them. I also understand that by not following my dentist's recommendation, delayed treatment can lead to but not limited to more discomfort, increase the complexity of the treatment outcome, or eventual loss of teeth.

4. EXTRACTION (REMOVAL OF TEETH)

I give my consent for doctor to perform the extraction/surgery to treat and possibly correct my diseased oral tissue, or other procedures deemed necessary or advisable to complete the planned operation/extraction. If left untreated, the risks to my health may include, but are not limited to swelling, pain, infection, cyst formation, gum diseases, dental decay, malocclusion, premature loss of teeth and/or bone. My Dentist has informed me of possible alternative methods of initials treatment.

POTENTIAL RISKS INCLUDE, BUT ARE NOT LIMITED TO THE FOLLOWING:

A. Post-operative discomfort, stretching of the corners of the mouth, with resultant (cracking and bruising, swelling, prolonged bleeding, tooth sensitivity to hot or cold; gum shrinkage possibly exposing crown margins) tooth looseness; (delayed healing dry socket) and/or infection requiring prescriptions or additional treatment, (i.e. surgery)

B. Injury to adjacent teeth, prosthesis, and or restorations which may require additional treatment or injury to other tissues not within the described surgical area.

C. Limitation on opening; stiffness of facial and/or neck muscles; change in bite or (Tempromandibular joint jaw joint) difficulty possibly requiring physical therapy or surgery.
D. Residual root fragments or bones spicules left when complete removal would require extensive surgery or needless surgical complications.
E. Possible bone, and/or jaw fracture, or opening of the maxillary sinus requiring additional surgery.
F. Injury to the nerve underlying the teeth resulting in itching, numbness, or burning of the lip, chin, gums, cheek, teeth, and/or tongue which may be temporary or permanent.

*If any unforeseen condition should arise in the course of the operation/extraction, calling for the doctor's judgment or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever s/he may deem advisable, including referral to another dentist or specialist.

5. **CROWNS, BRIDGES AND CAPS**

I understand sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand I may be wearing temporary crowns, which may come off easily and could be aspirated, and I must be careful to ensure that they are kept on until the permanent crowns are delivered. I understand if my temporary falls off, then it is my responsibility to return to my dentist to have it re-cemented. I realized the final opportunity to make changes in my new crown and bridge, or cap including shape, fit, size and color, will be before cementation. I understand if I do not return for my scheduled appointment for delivery of my crowns, or bridge, it may not fit properly, and I will be responsible for any lab.

6. **DENTURES-COMPLETE OR PARTIAL**

I realize full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture including shape, fit, size, placement, and color will be the "teeth in wax" try-in visit. I understand most dentures require relining approximately three to six months after initial placement and yearly thereafter. The cost for these relines is not included in the initial denture fee. I further understand that due to bone loss, lack of alveolar ridge support, muscle attachment and/or other complications factors, I may never be able to wear dentures to my satisfaction.

7. **ENDODONTIC TREATMENT ROOT CANAL**

The purpose and method of root canal therapy have been explained to me as well as consequences of non-treatment and reasonable alternative treatments. I understand that the following root canal therapy my tooth will be brittle and must be protected against fracture by placement of a final restorative usually a crown cap over the tooth. I also understand that sometimes root canal therapy may fail and further treatment may be necessary that might include but not limited to retreatment, apicoectomy, or extraction.

A. Post treatment discomfort, infection, restricted jaw opening.
B. Swelling of the gum area in the vicinity of the treated tooth or facial swelling, either of which may persist for several days or longer.
C. Separation of root canal instrument during treatment, which may in the judgment of the Dentist be left in the treated root canal or bone as part of the filling material, or it may require surgery for removal.
D. Perforation of the root canal which may require additional surgical treatment, or premature tooth loss extraction.
E. Risk of temporary or permanent numbness in treatment vicinity.
F. The root canal filling material may be overfilled or undefiled, which may or may not affect the success/ outcome of the treatment.

8. **PERIODONTAL LOSS TISSUE & BONE**

I understand that the long term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene i.e brushing and flossing and maintaining regular and maintenance visits. I understand that I have a serious condition causing gum and bone inflammation and/or loss that can lead to loss of my teeth and other related systemic complication. The various treatment plans have been explained to me, including non-surgical scaling and root planning followed by local irrigation with oral medicaments and local delivery of antibiotic, or gum surgery, or replacement and/or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. I understand that after following approved periodontal treatment there may still be a need for referral to a periodontics.

9. **FILLINGS**

I have been advised of the need for fillings, either silver or composite plastic. In cases where very little tooth structure remains or existing tooth structure fractures off, I may need to receive more extensive treatment such as root canal therapy, post and build up and crowns, which would necessitate a separate charge. I understand that my recently placed fillings may cause some sensitivity and discomfort for duration and may be alleviated with time. However I understand that if the symptom and sensitivity worsen, then I might need an RCT.

10. **PEDODONTICS (Children's Dentistry)**

I understand the following procedures are routinely used in conjunction with pediatric dentistry, as well as being accepted procedures in the dental profession. As the parent or authorized care giver, I understand and give consent that the following procedures can be used on my child.

- POSITIVE REINFORCEMENT – Rewarding the child who portrays desirable behavior, by use of compliments, verbal praises or toys.
- VOICE CONTROL – The attention of a disruptive child is gained by changing the tone or increasing the volume of the doctor's voice.
- PHYSICAL RESTRAINT – As the parent or authorized care giver, I have been informed in advance and have given consent as it may be deemed necessary to restrain the child, Restraining the child's disruptive movements by holding down their hands, upper body, head and/or legs by use of the dentist's or assistant's hand or arm, or by use of a special device referred to as a "PAPOOSE BOARD"

I understand that with the use of local anesthetic for dental purposes, the possibility exists that the child may inadvertently bite their lip, tongue, and cheek causing injury to occur.

I understand dentistry is not an exact science and therefore, practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding dental treatment, which I have requested and authorized. I have read and clearly understood the consent form language and by signing below I acknowledge this understanding and give my consent to You Smile Dental to perform the above indicated procedures[s]. My You Smile Dental doctor has encouraged me to ask questions. I have had the opportunity to ask question and any and all of my questions have been answered to my satisfaction.

SIGNATURE_____ DATE_____

DOCTOR_____ WITNESS _____