CONFIDENTIAL INFORMATION QUESTIONNAIRE

Please Print

PATIENT'S NAME LAST	FIRST	MIDDLE	DATE OF BIRTH	SEX	SOCIAL SECURITY #	
PATIENT'S ADDRESS STREET	APT #	CITY	STATE	ZIP	HOME PHONE	
MARITAL STATUS ☐M ☐S ☐D ☐W ☐UNDER AGE 18	PATIENT'S/GUARDIAN'S EMPLOYER		OCCUPATION			
WORK ADDRESS STREET	CITY	STATE	ZIP	WORK PHONE	OK TO CALL WORK? ☐YES ☐NO	
SPOUSE'S NAME LAST	FIRST	MIDDLE	PATIENT'S/GUARDIAN'S EMPLOYER		OCCUPATION	
WORK ADDRESS STREET	CITY	STATE	ZIP	WORK PHONE	OK TO CALL WORK? ☐YES ☐NO	
PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)						
NAME	RELATIONSHIP	WORK #	HOME #			
OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE	LET US KNOW HOW YOU HEARD ABOUT OUR OFFICE. TV NEWSPAPER MAIL FLYER YELLOW PAGES WEBSITE INSURANCE BILLBOARD OTHER _____					

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE ☐YES ☐NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS	
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	INSURANCE ADDRESS	
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 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 _____

Medical Information & History

Patient Name:_____Age_____

Personal Physician: _____Most recent physical exam date: ____/____/_____

CIRCLE YES OR NO:

Heart Problems	Yes	No
Cardiac Stent	Yes	No
History of Infective Endocarditis	Yes	No
Heart valve replacement or repair	Yes	No
Pacemaker	Yes	No
High or Low blood pressure (circle)	Yes	No
History of stroke	Yes	No
Taking blood thinners or aspirin	Yes	No
Prolonged bleeding due to slight cut	Yes	No
Anemia or blood disorder	Yes	No
Emphysema or sarcoidosis	Yes	No
Tuberculosis	Yes	No
Asthma	Yes	No
Breathing problems	Yes	No
Kidney disease	Yes	No
Liver disease	Yes	No
Thyroid disease	Yes	No
Diabetes (HbA1c=_____)	Yes	No
Gastric Reflux, IBS, or Ulcer	Yes	No
Glaucoma (type_____)	Yes	No
Epilepsy, convulsions, or seizures	Yes	No
Cold sores or canker sores	Yes	No
Hepatitis (type_____)	Yes	No
HIV	Yes	No
Tumor or abnormal growth	Yes	No
Radiation therapy	Yes	No
Chemotherapy	Yes	No
Mental or psychiatric treatment	Yes	No
Antidepressant medication	Yes	No
Alcohol or drug dependency	Yes	No
Migraines or frequent headaches	Yes	No
FEMALE – birth control medication	Yes	No
FEMALE – pregnant	Yes	No

ALLERGIC TO:

- ◯ Aspirin, Ibuprofen, Acetaminophen
- ◯ Codeine
- ◯ Penicillin
- ◯ Tetracycline
- ◯ Sulfa
- ◯ Local Anesthetic
- ◯ Latex
- ◯ Other _____

Describe any medical conditions, treatments, or surgeries that may affect dental treatment:

_____
_____
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List all medications and supplements: (Ask for additional sheet if needed-- or provide list from physician or pharmacy)

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Patient Signature_____ Date_____/_____/_____

Doctor Signature_____ Date_____/_____/_____

Dental Information & History

Patient Name:_____

Previous Dentist: _____Location:_____

Date of most recent dental exam: _____/_____/_____

What is your immediate dental concern?

_____

_____

Are you in pain? *YES* *NO*

If yes, for how long? _____

Type of pain: *Throbbing* *Aching* *Sharp* *Dull* *Severe*

Location: *UPPER* *LOWER* *RIGHT* *LEFT*

Do you have any swelling or a bump? *YES* *NO*

Are you fearful of dental treatment? *YES* *NO* How much? MILD MODERATE VERY

Please describe any problems you have had with the following:

Jaw:_____

Teeth:_____

Gums:_____

Have you ever been diagnosed or treated for gum disease? *YES* *NO*

Is there anything about your smile you would like to change? *YES* *NO*

Please tell us how we can make your visit more comfortable:

_____

Patient Signature _____Date_____/_____/_____

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are dedicated to serving your dental needs with the best professional advice, care and service available. Please understand that payment of your dental bill is considered a part of your treatment. Please read the following information, and if you have any questions, please ask.

Private Pay
Full payment is due at time of service. We accept cash, personal check, Visa, Mastercard, Discover, and American Express.

Payment Plans
If you would like to make payments, we are happy to offer CareCredit as our third party creditor. We can help you apply for this service.

Dental Insurance
Co-pays and deductibles are due at time of service. Filing your insurance claims is a service we are glad to provide at no cost to you, but does not relieve you of your responsibility for your bill.
Please provide us with a copy of your current dental benefit card. If you do not have a current card, payment in full may be required before treatment.

It is your responsibility to understand your dental benefit plan. Please understand that we file claims to many different benefit companies, and it is impossible for us to know your individual policy. Please be aware that some or all of the services provided may be subject to additional co-pays or deductibles as determined by your insurance company. You have a right to refuse services if you think they may not be covered or payable by your insurance company. We will not become involved in disputes between you and your insurance company regarding non-covered services, diagnoses, co-pays, or deductibles.

Authorization (please read entire paragraph and sign below)
I certify that I, and/or my dependant(s) have insured coverage with _____ and assign directly to Smile Station all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all treatment rendered regardless if covered by insurance or dental benefits. I authorize the use of my signature on insurance submissions. Smile Station may provide my health information to the above-named insurance company for the purpose of obtaining payment for service and determining benefits payable for related services.

I understand that if I fail to pay the entire balance within 30 days from the date of service, a service charge will be assessed each month. I realize that failure to keep the account current may result in denial of dental services. In the case of default on payment of this account, I agree to pay all collection costs and attorney fees incurred in collection attempts. I understand that I am responsible for all bank charges resulting from returned checks or closed accounts. A processing fee may be charged for returned checks.

_____ _____
Signature of Patient, Parent, Guardian, or Representative Date

_____ _____
Print Name of Patient, Parent, Guardian, or Representative Relationship to Patient