

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT NAME	LAST	FIRST	MIDDLE	DATE OF BIRTH	SOCIAL SECURITY #
PATIENT ADDRESS				HOME PHONE #	
EMAIL				CELL PHONE #	
SPOUSE'S NAME				SPOUSE'S CONTACT #	
EMPLOYER			OK TO CALL WORK?	WORK PHONE #	
WORK ADDRESS				PREFERRED CONTACT #	
IF MINOR, PARENT(S) NAME(S)				PARENT CONTACT #	
EMERGENCY CONTACT (OTHER THAN YOUR FAMILY HOME)					
NAME		RELATIONSHIP		CONTACT #	
OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE			HOW DID YOU HEAR ABOUT OUR OFFICE?		

INSURANCE AND FINANCIAL INFORMATION

PLEASE PRESENT CARD TO RECEPTIONIST AT CHECK IN

PATIENT RELATIONSHIP TO SUBSCRIBER	SUBSCRIBER'S NAME – IF NOT PATIENT		
SELF SPOUSE DEPENDENT			
SUBSCRIBER'S SOCIAL SECURITY #	DATE OF BIRTH	SUBSCRIBER'S EMPLOYER	
INSURANCE COMPANY NAME	MAILING ADDRESS		
PHONE NUMBER	GROUP NUMBER	PATIENT ID #	

ASSIGNMENT & RELEASE

I hereby authorize Dr. Mark T Frank DDS to submit insurance benefits on my behalf. I understand that insurance benefits will be paid directly to me.

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 policies.

I consent to the making of videotapes, photographs and x-rays before, during and after treatment, and to the 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 Electronically Signed/Dated Upon Upload

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, and at what age? _____
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? _____

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 do you 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 try to bite your back teeth together? _____
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____
25. Are your teeth becoming more crooked, crowded, or overlapped? _____
26. Are your teeth developing spaces or becoming more loose? _____
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, 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 or grind your teeth together in the daytime or make them sore? _____
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), 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 (shape, color, size)? _____
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 _____ Electronically Signed/Dated Upon Upload _____ 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

YES NO

- 1. hospitalization for illness or injury _____
- 2. an allergic or bad reaction to any of the following:
 aspirin, ibuprofen, acetaminophen, codeine
 penicillin
 erythromycin
 tetracycline
 sulfa
 local anesthetic
 fluoride
 metals (nickel, gold, silver, _____)
 latex
 nuts _____
 fruit _____
 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. pneumonia, 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 or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) _____

- 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____
- 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. diagnosed with a prostate disorder _____

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 _____ Electronically Signed/Dated Upon Upload _____ Date _____

Doctor's Signature _____ Date _____

Mark T. Frank, D.D.S.
3955 East Exposition Avenue, Suite 412
Denver, Colorado 80209

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient/Responsible Party Giving Consent:

Patient Name:

Today's Date:

Address:

Phone:

Section B: Please read the following statements CAREFULLY: NEW LAWS EFFECTIVE SEPTEMBER 23, 2013

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare options.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our policies as described in our Notice of Privacy Practices. If we change our Privacy Practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we will maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting the office manager at:

Telephone: (303) 722-2686

Address: 3955 East Exposition Avenue, Suite 412, Denver, Colorado 80209

Rights to Revoke: You have the right to revoke this consent at any time by giving us written notice your revocation submitted to the contact listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received it, and that we may decline to treat you or to continue treating you if you revoke this consent.

I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this form, I am giving my consent for the use and disclosure of my protected health information to carry out treatment, payment activities, and other healthcare operations.

Electronically Signed/Dated Upon Upload

Patient/Guardian Signature: _____ Date: _____

Mark T. Frank, D.D.S
3955 East Exposition Avenue, Suite 412
Denver, Colorado 80209
Phone: (303) 722-2686

OFFICE FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have dental insurance, we are willing to assist you in receiving your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of your payment policy. This financial policy meets the new HIPAA guidelines effective September 23, 2013.

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE WITH THE OFFICE MANAGER. We accept cash, checks, and Visa/MasterCard for payments. We are able to assist you in processing your insurance claim for your reimbursement. We must emphasize that as dental care providers, our relationship is with you and NOT your insurance company. While the filing of your insurance claims is a courtesy that we gladly extend to your patients, all charges are your responsibility from the date services are rendered.

Balances older than 60 days will be subject to additional interest charges of 5% per month; any balances over 120 days are subject to additional collection fees and reasonable attorney fees. There is a \$50,00 charge on all returned checks. A \$50.00 CHARGE WILL ALSO BE MADE FOR MISSED AND CANCELLED APPOINTMENTS WITHOUT A 24-HOUR ADVANCE NOTICE.

We will gladly discuss your proposed treatment plan and answer any questions related to your insurance. However, you must realize the following:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees generally fall within the acceptable range by most insurance companies, and therefore cover up to the maximum allowance determined by each carrier. This applies to those companies who pay a percentage of the Usual, Customary, and Reasonable fees (U.C.R.). Most insurance companies consider our fees U.C.R. This statement does not apply to those companies who reimburse based on an arbitrary fee schedule of their own that bears no relationship to the U.C.R fees for the region with which we are located.
3. Not all services are a covered benefit with insurance contracts. Depending on the contract provided by your employer with the insurance certain services will not be covered by the terms of this contract.

We realize that temporary financial problems may effect timely payment on your account. If such problems occur, it is your responsibility to contact us promptly for assistance in the management of your account.

Patient Name:

Date:

Electronically Signed/Dated Upon Upload

Patient/Guardian Signature