# 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<br>SELF SPOUSE DEPENDENT | SUBSCRIBER'S NAME – IF NOT PATIENT | |
|---|---|---|
| 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 ______________________________ 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 ______________________________________ 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 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) ____________

**YES NO**

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 ______________________________ Date ____________

Doctor's Signature ______________________________ Date ____________

**ASA ______ (1-6)**

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.

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. <u>We are not a party to that contract.</u>

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 <u>your responsibility</u> to contact us promptly for assistance in the management of your account.

Patient Name: Date:

________________________________________

Patient/Guardian Signature