Dental Questionnaire

Comprehensive Exam

Name:_____ **Date:**_____

Dental Treatment Questions:

1. Do you feel nervous about having dental treatment?..... ☐ **Yes** ☐ **No**
2. Do you want to discuss sedation options? ..... ☐ **Yes** ☐ **No**
3. Have you been treated with Orthodontics in the past?..... ☐ **Yes** ☐ **No**
4. Do you want straighter teeth?..... ☐ **Yes** ☐ **No**
5. Are you satisfied with the appearance of your teeth?..... ☐ **Yes** ☐ **No**
6. If you could have your teeth whitened, would you be interested?..... ☐ **Yes** ☐ **No**
7. Have you ever had an oral cancer exam?..... ☐ **Yes** ☐ **No**
8. Do you have areas that are difficult to floss?..... ☐ **Yes** ☐ **No**
9. Do you have areas where food catches between your teeth?..... ☐ **Yes** ☐ **No**
10. Have you noticed any spots or stains on your teeth that concern you?..... ☐ **Yes** ☐ **No**
11. Are there old fillings or dental work you would like to change?..... ☐ **Yes** ☐ **No**
12. Do you snore?..... ☐ **Yes** ☐ **No**
13. Do you wake up in the morning still feeling tired?..... ☐ **Yes** ☐ **No**
14. Do you have tired jaws, especially in the morning?..... ☐ **Yes** ☐ **No**
15. Do you wear removable dentures or partial dentures?..... ☐ **Yes** ☐ **No**
16. Are you using any other dental devices (i.e. retainer, bite guard, snoring appliance)?.. ☐ **Yes** ☐ **No**
17. Do you have an unpleasant taste or bad breath?..... ☐ **Yes** ☐ **No**
18. Do you think your dental health affects your overall physical health?..... ☐ **Yes** ☐ **No**

→

Please flip to the back.

Dental Hygiene Questions:

19. Date of last dental cleaning?.....

    What was the name of the office or dentist?.....

20. How often do you brush?.....

21. What do you use to clean your teeth/gums?.....

- ☐ **Manual Toothbrush**
- ☐ **Electric Toothbrush**
- ☐ **Floss**
- ☐ **Toothpick**
- ☐ **Waterpick**
- ☐ **Fluoride Rinse**
- ☐ **Tongue Blade**

22. Have you ever been told that you have periodontal disease?..... ☐ **Yes** ☐ **No**

23. Have you ever head a deep cleaning?..... ☐ **Yes** ☐ **No**

24. Do your gums bleed when brushing/flossing?..... ☐ **Yes** ☐ **No**

25. Are you currently using any prescription toothpaste or mouthwash?..... ☐ **Yes** ☐ **No**

Patient Intake Information

Patient Information

Name: _____ Today's Date: _____

DOB: _____ Age: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ □ Home □ Cell Alt Phone: _____

Email: _____ Primary Language: □ English □ Spanish □ Other: _____

Emergency Contact: _____
Name Relationship Phone

What is the reason for your visit / Chief Complaints? _____

_____

How did you hear about us? _____

Primary Insurance Information

Insurance Company: _____ Employer: _____

Policy Holder's Name: _____ Policy Holder DOB: _____

Policy Number: _____ Group Number: _____

Patient Relationship to Subscriber: _____

Secondary Insurance Information

Insurance Company: _____ Employer: _____

Policy Holder's Name: _____ Policy Holder DOB: _____

Policy Number: _____ Group Number: _____

Patient Relationship to Subscriber: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the above-named Insurance Company and assign directly to Dr. Dental all insurance benefits, if any, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named medical facility may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable to related services. This consent will stay in effect as long as I am a patient with the above-named medical facility.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative Name of Patient, Parent, Guardian, or Personal Representative (Print)

_____ _____
Date Relationship to Patient

Preferred Pharmacy Information

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Street Address: _____

Dental History and Oral Health

Date of last dental visit: _____ Date of last dental X-ray: _____

Have you ever been treated for periodontal disease? □ Yes □ No Have you ever had Novocaine / other local anesthetic? □ Yes □ No

One a scale of 1 (not happy) to 10 (very happy), how happy are you with your smile? _____

Please check any dental conditions that apply to you:

□ Pain in Jaw (TMJ) □ Teeth Grinding / Clenching □ Use Tobacco Products □ Swollen / Bleeding Gums

□ Mouth Sores □ Broken / Loose Teeth □ Sensitive Teeth □ Difficulty Chewing / Swallowing

□ Crooked / Spaced Teeth □ Tooth Color / Appearance

Are you in pain? □ Yes □ No Do you experience any fears or anxieties related to dental treatment? □ Yes □ No

If Yes, please explain: _____

Do you need to be pre-medicated before dental treatment? □ Yes □ No

Medical History

Primary Care Provider (Name and Phone): _____

Date of last physical: _____ Are you taking birth control? □ Yes □ No □ Not Applicable

Are you currently pregnant or nursing? □ Yes □ No □ Not Applicable Estimated due date, if applicable: _____

Please list any prior hospitalizations or surgeries, including dates: _____

_____

Is the patient currently using alcohol or drugs (including tobacco)? □ Yes □ No

If yes, Type: _____ Frequency: _____ Amount: _____

Do you require antibiotics prior to dental procedures? □ Yes □ No

Are you currently taking or have you taken any steroid / cortisone therapy in the last 2 years? □ Yes □ No

Are you currently taking or have you ever taken Oral Bisphosphonates (e.g. FOSAMAX, BONIVA) or IV Bisphosphonates? (e.g. ZOMETA, AREDIA)? □ Yes □ No If yes, for how long? _____

Are you allergic or have you ever had an adverse reaction to any of the following?

□ None □ Amoxicillin □ Aspirin □ Codeine □ Epinephrine □ Latex □ Ibuprofen
□ Metals □ Penicillin □ Sulfa □ Tetracycline □ Erythromycin □ Z-pack

Please specify any other known allergies: _____

Have you ever taken any of the group of drugs collectively referred to as “fen-phen”? These include combinations of Ionimin, Adipex, Fastin, (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). □ Yes □ No

Please list any current prescribed medications or supplements you are taking, or have used over a long period of time (e.g. prescription, dosage, dates):

Prescription / Supplement Name	Dosage/ Frequency	Dates

Conditions *(Please check all that apply)*

- ☐ None
- ☐ Alcoholism
- ☐ Allergies or Hives
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
  Type & Age: _____
- ☐ Aspirin Therapy
- ☐ Asthma
- ☐ Blood Thinners
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Cancer
  Type: _____
- ☐ Chemotherapy
- ☐ Coumadin Therapy
- ☐ Dementia
- ☐ Diabetes
  Type: _____
- ☐ Drug Addiction
- ☐ Epilespy
- ☐ Excessive Bleeding
- ☐ Fainting / Dizziness
- ☐ Hearing Impairment / Loss
- ☐ Heart Murmur
- ☐ Heart Surgery
  Type: _____
- ☐ Heart Trouble
  Type: _____
- ☐ Hepatitis
  Type: _____
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease / COPD
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Mobility Impairment
- ☐ NON-DENTAL Implants
  Type: _____
- ☐ Organ Transplants
  Type: _____
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Therapy
- ☐ Radiosurgery
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Visual Impairment
- ☐ Other Disease / Illness
  Type: _____
  _____

_____ _____

Patient Signature **Date**

_____ _____

Doctor's Signature **Date**

Informed Consent to Treatment

Drugs and Medication
I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction).
(Initial: _____)

Changes in Treatment Plan
I understand that during treatment, it may be necessary to change or add procedures because of conditions 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 they've been discovered and discussed. (Initial: _____)

X-Rays
I understand x-rays are necessary for proper diagnosis and treatment. (Initial: _____)

Fillings
I understand that care must be exercised in chewing on fillings, especially during the first 24 hours, to avoid breakage.
I understand that a more expensive filling may be required due to additional decay than what could be seen by the x-ray and that significant sensitivity is a common aftereffect of a newly placed filling. (Initial: _____)

Local Anesthetic
Anesthetizing agents (medications) are injected into a small area with the intent of numbing the area to receive dental treatment. They also can be injected near a nerve to act as a nerve block causing numbness to a larger area of the mouth beyond just the site of injection. Risks include but are not limited to.' It is normal for the numbness to take time to wear off after treatment, usually two to three hours. This can vary depending on the type of medication used. However, in some cases, it can take longer, and in some rare cases, the numbness can be permanent if the nerve is injured. Infection, swelling, allergic reactions, discoloration, headache, tenderness at the needle site, dizziness, nausea, vomiting, and cheek, tongue, or lip biting can occur. Potential benefits: The patient remains awake and can respond to directions and questions. Pain is lessened or eliminated during dental treatment. (Initial: _____)

I understand that dentistry is not an exact science, and therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions, and my questions have been answered to my satisfaction. I consent to the proposed treatment.
(Initial: _____)

General Consent to Treatment

1. I hereby authorize and direct the dentist and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.
2. I understand x-rays, photographs, models of the mouth, and/or other diagnostic aids used for an accurate diagnosis and treatment planning are the property of the doctors, but copies of certain aids are available upon request for a fee.
3. In general terms, the dental procedure(s) can include is not limited to:
    a. Comprehensive oral examination, radiographs, cleaning of the teeth, and the application of topical fluoride
    b. Application of resin "sealants" to the grooves of the teeth
    c. Treatment of diseased or injured teeth with dental restorations (fillings)
    d. Treatment of diseased or injured oral tissue secondary to traumatic injuries and/or accidents and/or infections
4. I understand that the doctor is not responsible for previous dental treatment performed in other offices. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that guarantees of results or absolute satisfaction are not always possible in dental health service.
5. I certify that if I and/or my dependents have insurance coverage, I assign directly to the dentist all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
6. I have answered all of the questions about me or my dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all medical conditions, including allergies. I also understand if my dependent or I ever have any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment.

7.

I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner, and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.

Patient Name (Print)

Patient or Parent | Guardian Signature

Date

ACKNOWLEDGEMENT FORM

I have received the "**Notice of Privacy Practices**" and have been provided an opportunity to review it.

_____	_____
Patient Name (Print)	Patient Date of Birth
_____	_____
Parent | Guardian Name if Patient is a Minor (Print)	Relationship to Patient
_____	_____
Signature	Date

DENTAL TREATMENT CONSENT FORM

Dentist's Name_____ Patient's Name:_____

Please read and initial the items checked below and read and sign at the bottom of form.

☐ **1. X-RAYS** (Initials_____)

☐ **2. DRUGS AND MEDICATIONS**
I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). (Initials_____)

☐ **3. CHANGES IN TREATMENT PLAN**
I understand that during treatment it may be necessary to change or add procedures because of conditions 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. (Initials_____)

☐ **4. REMOVAL OF TEETH**
Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.
(Initials_____)

☐ **5. CROWNS, BRIDGES AND CAPS**
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation.
(Initials_____)

☐ **6. DENTURES, COMPLETE OR PARTIAL**
I realize that 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 dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.
(Initials_____)

☐ **7. ENDODONTIC TREATMENT (ROOT CANAL)**
I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). (Initials_____)

☐ **8. PERIODONTAL LOSS (TISSUE & BONE)**
I understand that care must be exercised in chewing on fillings especially during the first 24 months to avoid breakage. I understand that a more expensive filling that initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. (Initials_____)

☐ **9. FILLINGS**
I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more expensive filling that initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filing. (Initials_____)

☐ **10. DENTURES**
I understand the wearing of dentures is difficult. Sore spots altered speech and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fixed dentures. If a remake is required due to my delays of more than 30 days there will be additional charges. (Initials_____)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient_____ Date_____

Signature of Parent/Guardian if patient is a minor_____ Date_____

FINANCIAL POLICY CONSENT FORM

We welcome you and your family to Bliss Family Dental. We look forward to providing you with quality dental care at affordable prices. To provide you with the most beneficial and comprehensive service and care, we request you review and complete or office and financial policy consent form. We will be happy to answer any questions you may have regarding the proposed treatment and available financial options. We strive to keep you informed and involved with your dental treatment.

Dental Insurance benefits: You need to be aware that:

We will always do our best to help you to maximize your benefits. Although we file claims for you as a courtesy, your dental insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract.

Your treatment plan is individually tailored, and is not based on your dental insurance benefits or lack of benefits. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy. Coverage issues can only be addressed by your employer or group plan administrator. We cannot act as a mediator with the carrier or your employer.

Dental Insurance Claim Payments:

As a courtesy to all of our insured patients, we will file your dental insurance claim forms. In special circumstances, a particular insurance company's benefit check can be sent to our office directly. In such cases, you are responsible at the time of treatment for payment to us of any applicable deductible and for your co-insurance portion. Any payments made directly to you by your insurance company on unpaid balances should be forwarded immediately to our office so that your account may be credited accordingly.

Your claim will be filed immediately, and benefits are expected to be paid within 30-45 days. The filing of an insurance claim does not relieve you of timely payment on your account. If the claim is not cleared by your carrier in 60 days, the unpaid portion will automatically become "self-pay" and a statement will be issued to you for the unpaid portion. You are responsible for any amounts your insurance company chooses not to pay for whatever reason.

I _____understand and accept the financial and insurance policies listed above and have had any and all questions answered to my satisfaction.

I_____ agree to pay for all treatment in a timely fashion as described.

Fill Out Front & Back

I _____ hereby authorize my insurance benefits to be paid directly to Bliss Family Dental. I realize that I am responsible to pay for any deductible amount(s), my co-insurance portion and for any non-covered services the day of service. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance. I agree to pay such charges in full.

I _____ hereby authorize the release of pertinent medical/dental information to the insurance carrier(s). This order will remain in effect until revoked by me in writing. A photocopy of this assignment is available by request.

PAYMENT OPTIONS AVAILABLE

:Cash/ Personal Check

:Most Major Credit and Debit Cards

:CareCredit -OAC

Patient/Legal Guardian	Date	Witness	Date

Fill Out Front & Back

HIPAA Compliance Patient Consent Form

Our Notice Of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations
- The practice reserves the right to change the privacy policy as allowed by law
- The practice has the right to restrict the use of information, but the practice does not have to agree to those restrictions
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease
- The practice may condition receipt of treatment upon execution of this consent

May we phone, email or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your dental conditions with any member of your family?	YES	NO

If YES, please name the family members allowed:

_____

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____