PREFERRED FAMILY DENTAL

www.pfdent.com
(937) 836-7282

CONFIDENTIAL INFORMATION QUESTIONNARE

PATIENT'S NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SEX	SOCIAL SECURITY #

PATIENT'S ADDRESS (STREET, APT #, CITY, STATE, ZIP)	EMAIL (FOR REMINDERS)	HOME PHONE

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

WORK ADDRESS (STREET, APT #, CITY, STATE, ZIP)	CELL PHONE	WORK PHONE	CALL WORK
			☐YES ☐NO

SPOUSE'S NAME (LAST, FIRST, MIDDLE)	SPOUSE'S EMPLOYER	SPOUSE'S OCCUPATION

SPOUSE'S WORK ADDRESS (STREET, APT #, CITY, STATE, ZIP)	SPOUSE'S PHONE	SPOUSE'S WORK PHONE	CALL WORK
			☐YES ☐NO

EMERGENCY CONTACT (OTHER THAN YOUR FAMILY HOME)

NAME: RELATIONSHIP HOME # CELL#

OTHER FAMILY MEMBERS THAT ARE PATIENTS OF OURS:	WHO CAN WE THANK FOR REFFERING YOU TO OUR OFFICE?

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE	INSURANCE COMPANY(NAME, ADDRESS, PHONE)
☐YES ☐NO	

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SSN

GROUP/PROGRAM #	EMPLOYER(IF DIFFERENT FROM ABOVE)	EMPLOYER ADDRESS

SECONDARY COVERAGE	INSURANCE COMPANY(NAME, ADDRESS, PHONE)
☐YES ☐NO	

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SSN

GROUP/PROGRAM #	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 video, photographs, and x-rays before, during, and after treatment, and to the use of same by 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**___________________________________

FINANCIAL RESPONSIBILITY

Dental treatment is an excellent investment in you and your family's health and well being. Because of this, we believe financial considerations should not be an obstacle to obtaining procedures. **PAYMENT AT TIME OF SERVICE IS EXPECTED**. In situations involving large treatment plans and/or insurance benefits, we provide 2 payment options. We are sensitive to the fact that different patients have different needs, so the following are the financial options available to our patients.

CASH, CHECK or CREDIT CARDS
We accept cash, personal and certified checks as well as VISA, MasterCard and Debit Cards

LOW MONTHLY PAYMENT PLAN
Our office currently provides outside financing arrangements for our patients. These are specifically designed for dentistry and related specialties – with low monthly payments. (Subject to Approval)

- Interest Free Options (3/6/12 months)
- No Initial Payment
- Low, fixed rates ranging from 4.0%-12%
- Low monthly payments
- No prepayment penalty, terms up to 60 months
- Quick and easy application process. Same day approval.

Insurance Coverage
Our practice will be happy to assist you in determining whether your insurance company will cover your dental services. As a COURTESY, our office will file your claim with your insurance company, and initiate correspondence with the purpose of getting you the maximum coverage your insurance will allow; however, if we do not receive payment from your insurance company within 60 days, the payment becomes your responsibility. If needed, a pre-treatment estimate will be sent to your insurance company to determine what benefit you will receive. Patients are responsible for any portion, "patient portion" not covered by insurance, which will be due at the time of service and please be aware that this is ONLY an estimated dollar amount. The policy of some insurance carriers is to pay benefits directly to the patient; in this event the patient is responsible for full payment at the time the service is rendered.

DENTAL INSURANCE PATIENTS
I understand my dental insurance is a contract between myself and the insurance carrier, not with Preferred Family Dental. As such, I understand that I am responsible for the full amount of all dental fees incurred. Any payments received by Preferred Family Dental from my insurance carrier will be credited to my account or refunded to me IF I have paid the dental fees incurred.

I understand that the payment of my bill is my legal obligation as the patient. I further agree to pay returned check charges of $35.00 per returned check. If this account is placed in the hands of an outside collection agency, I agree to pay the fees incurred by that agency in regards to the collection process.

Patient Signature______________________________ **Date**______________________

Financial Coordinator Signature______________________________ **Date**______________________

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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

Most Recent Dental Exam ____/_____/______ Most Recent Dental x-ray_____/_____/_____

Most Recent Dental Treatment (other than a cleaning) ___/___/____

I routinely see my dentist every: ☐3Mo ☐6Mo ☐ 1 Year or Longer

What is your immediate dental concern? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING

Personal History

1. Are you fearful of dental treatment? Scale of 1 to 10 (very)____ ☐Y ☐N
2. Have you had an unfavorable dental experience? ☐Y ☐N
3. Have you ever had complications from past dental treatment? ☐Y ☐N
4. Have you ever had trouble getting numb or reactions to local anesthetic? ☐Y ☐N
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? ☐Y ☐N
6. Have you had any teeth removed? ☐Y ☐N

Smile Characteristics

7. Is there anything about the appearance of your teeth that you would like to change? ☐Y ☐N
8. Have you ever whitened (bleached) your teeth? ☐Y ☐N
9. Are you self conscious about your teeth? ☐Y ☐N
10. Have you been disappointed with the appearance of previous dental work? ☐Y ☐N

Bite and Jaw Joint

11. Do you have any problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ☐Y ☐N
12. Do you / would you have any problems chewing gum? ☐Y ☐N
13. Do you / would you have any problems chewing bagels, baguettes, protein bars, or other hard foods? ☐Y ☐N
14. Have your teeth changed in the last 5 years, become shorter, thinner, or worn? ☐Y ☐N
15. Are your teeth crowding or developing spaces? ☐Y ☐N
16. Do you have more than one bite or do you squeeze to make your teeth fit together? ☐Y ☐N
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ☐Y ☐N
18. Do you clench your teeth in the daytime or make them sore? ☐Y ☐N
19. Do you have problems with sleep or wake up with awareness of your teeth? ☐Y ☐N
20. Do you wear or have you ever worn a bite appliance? ☐Y ☐N

Tooth Structure

21. Have you had cavities within the past 3 years? ☐Y ☐N
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ☐Y ☐N
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ☐Y ☐N
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any parts of your mouth? ☐Y ☐N
25. Do you have any grooves or notches on your teeth near the gum line? ☐Y ☐N
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ☐Y ☐N
27. Do you get food caught between your teeth? ☐Y ☐N

Gum and Bone

28. Do your gums bleed when brushing, flossing, or eating? ☐Y ☐N
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? ☐Y ☐N
30. Have you ever noticed an unpleasant taste or odor in your mouth? ☐Y ☐N
31. Is there anyone with a history of periodontal disease in your family? ☐Y ☐N
32. Have you ever experienced gum recession? ☐Y ☐N
33. Have you ever had any teeth become loose on their own, or do you have difficulty eating an apple? ☐Y ☐N
34. Have you experienced a burning sensation in your mouth? ☐Y ☐N

Patient Signature____ **Date**___________________________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

DO NOT SIGN IF YOU HAVE NOT RECEIVED

I, ___________________________________ have received a copy of the Privacy Practices of Preferred Family Dental, Inc.

Patient Signature____________________________________ **Date**_________________________

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, receipt could not be obtained because:

- ☐ Individual refused to Sign
- ☐ Communications barriers prohibiting obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify)

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MEDICAL HISTORY

Patient Name ___________________________ Primary Care Doctor ______________________________
Most Recent Physical Exam ________________________ Purpose________________________________
Please rate your overall health? ☐ Poor ☐ Fair ☐ Good
Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment____

HAVE YOU EVER HAD THE FOLLOWING?

1. Hospitalization for illness of injury ☐Y ☐N
2. **Allergic reaction to:**
   - a. *Aspirin, ibuprofen, acetaminophen* ☐*Y* ☐*N*
   - b. *Penicillin* ☐*Y* ☐*N*
   - c. *Erythromycin* ☐*Y* ☐*N*
   - d. *Tetracycline* ☐*Y* ☐*N*
   - e. *Codeine* ☐*Y* ☐*N*
   - f. *Local anesthetic* ☐*Y* ☐*N*
   - g. *Fluoride* ☐*Y* ☐*N*
   - h. *Metals(gold, stainless steel)* ☐*Y* ☐*N*
   - i. *Latex* ☐*Y* ☐*N*
   - j. *Any other medications* ☐Y ☐N
3. Heart problems ,or cardiac stent within 6 months ☐Y ☐N
4. History of infective endocarditis ☐Y ☐N
5. Artificial heart valve, repaired defect ☐Y ☐N
6. Pacemaker or implantable defibrillator ☐Y ☐N
7. Artificial prosthesis-heart valve or joints ☐Y ☐N
8. Rheumatic or scarlet fever ☐Y ☐N
9. High or low blood pressure ☐Y ☐N
10. A stroke ☐Y ☐N
11. Anemia or blood disorder ☐Y ☐N
12. Prolonged bleeding due to a slight cut ☐Y ☐N
13. Emphysema, sarcoidosis ☐Y ☐N
14. Tuberculosis ☐Y ☐N
15. Asthma ☐Y ☐N
16. Breathing or sleeping problems ☐Y ☐N
17. Kidney disease ☐Y ☐N
18. Liver disease ☐Y ☐N
19. Jaundice ☐Y ☐N
20. Thyroid/parathyroid disease ☐Y ☐N
21. Hormone deficiency ☐Y ☐N
22. High cholesterol or taking statin drugs ☐Y ☐N
23. Diabetes (HbA1C____) ☐Y ☐N
24. Stomach or duodenal ulcer ☐Y ☐N
25. Digestive disorders(ie. Reflux) ☐Y ☐N
26. Arthritis ☐Y ☐N
27. Osteoporosis/Osteopenia (i.e bisphophonates) ☐Y ☐N
28. Glaucoma ☐Y ☐N
29. Contact lenses ☐Y ☐N
30. Head or neck injuries ☐Y ☐N
31. Epilepsy, convulsions (seizues) ☐Y ☐N
32. Neurolic problems-attention deficit disorder ☐Y ☐N
33. Viral infections and cold sores ☐Y ☐N
34. Any lumps or swelling in the mouth ☐Y ☐N
35. Hives, skin rash, hay fever ☐Y ☐N
36. Venereal disease ☐Y ☐N
37. Hepatitis (type_______) ☐Y ☐N
38. HIV ☐Y ☐N
39. AIDS ☐Y ☐N
40. Tumor/abnormal growth ☐Y ☐N
41. Radiation therapy ☐Y ☐N
42. Chemotherapy ☐Y ☐N
43. Emotional or Psychiatric treatment ☐Y ☐N
44. Antidepressant medication ☐Y ☐N
45. Alcohol/drug dependency ☐Y ☐N

ARE YOU?

46. Presently being treated for an illness ☐Y ☐N
47. Aware of a change in your health ☐Y ☐N
48. Taking meds for weight management ☐Y ☐N
49. Often exhausted or fatigued ☐Y ☐N
50. Subject to frequent headaches ☐Y ☐N
51. A smoker ☐Y ☐N
52. Considered a touchy person ☐Y ☐N
53. Often unhappy or depressed ☐Y ☐N
54. Easily upset or irritated ☐Y ☐N
55. FEMALE – Taking birth control ☐Y ☐N
56. FEMALE – Pregnant ☐Y ☐N
57. MALE – Prostate disorders ☐Y ☐N

MEDICATIONS (TAKEN WITHIN LAST TWO YEARS)
Please include Vitamins or Herbal supplements

Patient Name____ Date_________________

Name of Drug	Purpose/Medical Condition	Strength/Dosage	How many times per day?	Date of Last Dose

Patient Signature____ **Date**__________________________