

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S NAME			LAST	FIRST	MIDDLE	DATE OF BIRTH	SEX	SOCIAL SECURITY #		
PATIENT'S ADDRESS			STREET	APT#	CITY	STATE	ZIP	EMAIL	HOME PHONE	
MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> UNDER AGE 18			PATIENT'S/GUARDIAN'S EMPLOYER				OCCUPATION			
WORK ADDRESS			STREET	CITY	STATE	ZIP	CELL PHONE	WORK PHONE	OK TO CALL WORK <input type="checkbox"/> YES <input type="checkbox"/> NO	
SPOUSE'S NAME			LAST	FIRST	MIDDLE	SPOUSE'S EMPLOYER		OCCUPATION		
WORK ADDRESS			STREET	CITY	STATE	ZIP	CELL PHONE	WORK PHONE	OK TO CALL WORK <input type="checkbox"/> YES <input type="checkbox"/> NO	
PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)										
NAME			RELATIONSHIP		HOME #	WORK #	CELL #			
OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE					WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE					

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO		INSURANCE COMPANY NAME			ADDRESS		PHONE	
SUBSCRIBER'S NAME		PATIENT'S RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT		SUBSCRIBER'S DATE OF BIRTH		SUBSCRIBER'S SSN		
GROUP/PROGRAM NUMBER		EMPLOYER (IF DIFFERENT FROM ABOVE)			EMPLOYER ADDRESS			
SECONDARY COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO		INSURANCE COMPANY NAME			ADDRESS		PHONE	
SUBSCRIBER'S NAME		PATIENT'S RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> 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 dentist. I am financially responsible for any balances due and authorize the dentist 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 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 _____

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 _____ | <input type="checkbox"/> | <input type="checkbox"/> | 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. an allergic reaction to _____ | | | 27. arthritis _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine | | | 28. glaucoma _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> penicillin | | | 29. contact lenses _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> erythromycin | | | 30. head or neck injuries _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> tetracycline | | | 31. epilepsy, convulsions (seizures) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> sulfa | | | 32. neurologic problems (attention deficit disorder) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> local anesthetic | | | 33. viral infections and cold sores _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> fluoride | | | 34. any lumps or swelling in the mouth _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> metals (nickel, gold, silver, _____) | | | 35. hives, skin rash, hay fever _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> latex | | | 36. venereal disease _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> other _____ | | | 37. hepatitis (type _____) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. heart problems, or cardiac stent within the last six months _____ | <input type="checkbox"/> | <input type="checkbox"/> | 38. HIV / AIDS _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. history of infective endocarditis _____ | <input type="checkbox"/> | <input type="checkbox"/> | 39. tumor, abnormal growth _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. artificial heart valve, repaired heart defect (PFO) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 40. radiation therapy _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. pacemaker or implantable defibrillator _____ | <input type="checkbox"/> | <input type="checkbox"/> | 41. chemotherapy _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. artificial prosthesis (heart valve or joints) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 42. emotional problems _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. rheumatic or scarlet fever _____ | <input type="checkbox"/> | <input type="checkbox"/> | 43. psychiatric treatment _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. high or low blood pressure _____ | <input type="checkbox"/> | <input type="checkbox"/> | 44. antidepressant medication _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. a stroke (taking blood thinners) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 45. alcohol / street drug use _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. anemia or other blood disorder _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 12. prolonged bleeding due to a slight cut (INR > 3.5) _____ | <input type="checkbox"/> | <input type="checkbox"/> | ARE YOU: | | |
| 13. emphysema, sarcoidosis _____ | <input type="checkbox"/> | <input type="checkbox"/> | 46. presently being treated for any other illness _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. tuberculosis _____ | <input type="checkbox"/> | <input type="checkbox"/> | 47. aware of a change in your health (i.e. fever, new cough) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. asthma _____ | <input type="checkbox"/> | <input type="checkbox"/> | 48. taking medication for weight management (i.e. fen-phen) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. breathing or sleep problems (i.e. snoring, sinus) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 49. taking dietary supplements _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. kidney disease _____ | <input type="checkbox"/> | <input type="checkbox"/> | 50. often exhausted or fatigued _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. liver disease _____ | <input type="checkbox"/> | <input type="checkbox"/> | 51. experiencing frequent headaches _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. jaundice _____ | <input type="checkbox"/> | <input type="checkbox"/> | 52. a smoker, smoked previously or use smokeless tobacco _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. thyroid, parathyroid disease, or calcium deficiency _____ | <input type="checkbox"/> | <input type="checkbox"/> | 53. considered a touchy person _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. hormone deficiency _____ | <input type="checkbox"/> | <input type="checkbox"/> | 54. often unhappy or depressed _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. high cholesterol or taking statin drugs _____ | <input type="checkbox"/> | <input type="checkbox"/> | 55. FEMALE - taking birth control pills _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. diabetes (HbA1c = _____) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 56. FEMALE - pregnant _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. stomach or duodenal ulcer _____ | <input type="checkbox"/> | <input type="checkbox"/> | 57. MALE - prostate disorders _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. digestive disorders (i.e. gastric reflux) _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Describe any current medical treatment, impending surgery, 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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Ask for an additional sheet if you are taking more than 6 medications

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 _____



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? _____
6. Have you had any teeth removed? _____

SMILE CHARACTERISTICS



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

BITE AND JAW JOINT



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

TOOTH STRUCTURE



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

GUM AND BONE



28. Do your gums bleed or are they painful when brushing or flossing? _____
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____
30. Have you ever noticed an unpleasant taste or odor in your mouth? _____
31. Is there anyone with a history of periodontal disease in your family? _____
32. Have you ever experienced gum recession? _____
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____
34. Have you experienced a burning sensation in your mouth? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

FINANCIAL POLICY

We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile with respect to your budget.

DENTAL INSURANCE

We are happy to file the forms necessary to see that you receive the full benefits of your coverage. In order to achieve this, we need your assistance in providing complete and accurate insurance information on our Confidential Information Form. We will do everything possible to see that you receive your full benefit, but we require payment of any unpaid deductible, copayments and coinsurance for services provided in the office at the time services are rendered. For policies where the insurance company pays to you and not the doctor, payment in full is expected at the time of service. **If you find that your insurance does not cover certain services or pays below our usual charge, we encourage you to discuss such issues with your insurance carrier and employer.** If you do not inform us of any special requirements in your insurance contract and we subsequently order services (such as x-rays, diagnostic casts, exams) which are not covered, we will bill you directly for those charges. Payment is your responsibility. **IF FOR SOME REASON INSURANCE HAS NOT PAID THEIR PORTION WITHIN 60 DAYS FROM THE START OF TREATMENT, THEN YOU ARE RESPONSIBLE FOR PAYING AT THAT TIME.** _____ (initial)

Also, please be minded that we do not accept third party liability such as: workman's compensation, pending litigation, divorced spouse, and other indirect insurance responsibilities. Full payment for office care is due at the time services are rendered. Return checks are subject to a \$20 processing fee, and may also be turned over to the District Attorney for additional processing and fees.

PAYMENT OPTIONS

Cash or Check: We are happy to offer a 5% discount for payment in full for fees over \$300 at the time of service

Credit Cards: For your convenience, we have made arrangements to accept VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS

Payment Plans: Our office is not equipped to carry payment plans for our patients, BUT...

1. We have made arrangements with finance companies who offer the option of monthly payments. There is no application fee or down payment, and the loan may be interest-free. Applications are available here.
2. We offer automatic credit card payments each month for a pre-authorized amount

PATIENT AGREEMENT:

I understand that payment of this charge is my responsibility and in the event of partial payment or non-payment by my insurance company, I remain responsible for payment to Eleanor A. Gill, DMD. I also understand that co-pays are expected at the time services are rendered. Should litigation be necessary, I will be responsible for all costs, including, but not limited to, court costs and attorney's fees.

Signature

Date

(OVER)

In addition to the financial policy, I understand the following:

- If my insurance does not pay their portion to Eleanor A. Gill, D.M.D, within 60 days from the start of treatment, then I authorize Eleanor A. Gill, D.M.D. to transfer any unpaid balance to the credit card listed below.
- The transfer will only take place after I have been contacted by a staff member to inform me of the balance due. Until then, this information will be protected and stored in a secure location.
- I understand that once the balance is transferred to my credit card, it will then become my responsibility to collect any reimbursement directly from the insurance company.

I authorize Dr. Eleanor A. Gill to bill the TOTAL balance on my account, after 60 days, to the credit card listed below. This balance may include any outstanding unpaid insurance claims that have not been paid within the 60 day grace period. **I understand that I will be notified by a staff member before any balance is transferred to my credit card.**

Credit Card Number _____

Expiration Date _____ 3 Digit Security Code _____

Statement Mailing Address _____

Signature _____



WHAT DON'T YOU LIKE ABOUT YOUR TEETH?

- | | |
|---|--|
| <input type="checkbox"/> CROWDING/CROOKED TEETH | <input type="checkbox"/> JAW JOINT PAIN |
| <input type="checkbox"/> SPACES | <input type="checkbox"/> MISSING TEETH |
| <input type="checkbox"/> TOOTH SHAPE | <input type="checkbox"/> DARK TEETH |
| <input type="checkbox"/> TOOTH SIZE | <input type="checkbox"/> SPEECH PROBLEMS |
| <input type="checkbox"/> GUMMY SMILE | <input type="checkbox"/> OVERBITE |
| <input type="checkbox"/> UNDERBITE | <input type="checkbox"/> FACIAL PROFILE |
| <input type="checkbox"/> TEETH ARE DIFFERENT COLORS | <input type="checkbox"/> UGLY OLD CROWNS |
| <input type="checkbox"/> OTHER _____ | |

I AM INTERESTED IN:

- SIX MONTH SMILES (Short-term orthodontic treatment)
- TEETH WHITENING
- VENEERS
- OTHER _____

IS THERE ANYTHING YOU WOULD LIKE THE DENTIST TO KNOW?
