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 ❑ M ❑ S ❑ D ❑ W ❑ UNDER AGE 18	PATIENT'S/GUARDIAN'S EMPLOYER	OCCUPATION

WORK ADDRESS	STREET	CITY	STATE	ZIP	CELL PHONE	WORK PHONE	OK TO CALL WORK ❑ YES ❑ 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 ❑ YES ❑ 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 COVERAGE ❑ YES ❑ NO	INSURANCE COMPANY NAME	ADDRESS	PHONE

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ❑ SELF ❑ SPOUSE ❑ DEPENDENT	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SSN

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

SECONDARY COVERAGE ❑ YES ❑ NO	INSURANCE COMPANY NAME	ADDRESS	PHONE

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ❑ SELF ❑ SPOUSE ❑ 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 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 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 _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	
Do you need to pre-medicate?	Yes	No	If yes, please explain: _____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain:

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Dental History

Patient Name: _____ **Birth Date**_____

Previous dentist_____ **How long** _____

Referred by _____

Most recent dental exam _____ **Most recent dental x-ray**_____

Most recent dental treatment _____

How often do you have your teeth cleaned? ___3 months __4 months __6 months ___1 year or longer

WHAT IS YOUR IMMEDIATE DENTAL CONCERN?

_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

1. Unhappy with the appearance of your teeth..... YES NO
2. Unfavorable dental experiences..... YES NO
3. Dental fears..... YES NO
4. Problems with effectiveness or bad reaction to dental anesthetic..... YES NO
5. Orthodontic treatment (braces) when?_____ YES NO
6. Periodontal (gum) treatment, when?_____ YES NO
7. Bleeding gums..... YES NO
8. Avoid brushing any part of your mouth..... YES NO
9. Part of your mouth is sensitive to temperature..... YES NO
10. Sore teeth..... YES NO
11. A burning sensation in your mouth..... YES NO
12. Difficulty swallowing..... YES NO
13. An unpleasant taste or odor in your mouth..... YES NO
14. Dry mouth, throat, and or eyes..... YES NO
15. Jaw problems (temporomandibular joint)..... YES NO
16. Difficulty opening your mouth widely..... YES NO
17. Stiff neck muscles..... YES NO
18. Awaken with an awareness of your teeth or jaws..... YES NO
19. Tension headaches..... YES NO
20. Clench or grind your teeth..... YES NO
21. Jaw clicking or popping..... YES NO
22. Lost any teeth..... YES NO
23. Do you sweat or tremble a lot during examination..... YES NO

SUPPLEMENTAL DENTURE HISTORY:

If you are wearing a partial or complete artificial denture, please complete the following:
(please Circle Yes or No)

YES NO Has your present denture been relined? When? _____
YES NO Is your present denture a problem? Describe_____
YES NO Satisfied with the appearance? _____
YES NO Satisfied with the comfort? _____
YES NO Satisfied with the chewing ability? _____

When did you receive your first partial or complete denture? _____
How long have you worn your present denture? _____

Patient Signature: _____ Date _____

Doctor's Remarks: _____

Doctor's Signature _____ Date _____

Notice of Privacy Practices Acknowledgement—Staton Family Dentistry

Trevor Staton DMD

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706-745-9621

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights of privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in my treatment plan—directly or indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use ONLY:
I attempted to obtain the patient's signature in acknowledgement of receipt of Notice of Privacy Practices, but was unable to do so as documented below:
Date: _____ **Initials:** _____ **Reason:** _____