# GET AQUAINTED QUESTIONAIRE

| PATIENT INFORMATION | | |
|---|---|---|
| Name: | | |
| Date of birth: | SSN: | Phone: |
| Current address: | | |
| City: | State: | ZIP Code: |
| Home Phone: | Cell Phone: | Email: |
| Employer: | | |
| Whom may we thank for referring you to our office? | | |

| ACCOUNT INFORMATION | | |
|---|---|---|
| Person responsible for payment of account (Insurance Holder): | | |
| Address: | | Phone: |
| City: | State: | Zip Code: |
| SS: | DOB: | Relationship: |
| Employer: | | |
| Insurance Company: | | Phone: |
| Address: | | |
| City: | State: | ZIP Code: |
| Group# | ID# | SS# |

I hereby agree to the use of any procedures, sedative analgesics or anesthetics as are deemed proper and necessary for dental treatment or diagnosis, and I authorize the use of any photographs and video tapes taken for the purpose of dental education.

| | |
|---|---|
| Signature of patient: | Date |
| Signature of guardian if under 18: | Date |

# HEALTH HISTORY

| **Name** | | | | | | **Date** | | | |
|---|---|---|---|---|---|---|---|---|---|
| Allergies | | | | **DOB** | | | | **Age** | |
| Height | | Weight | | Blood pressure | | Pulse | | Sex | |

| **PROBLEMS ADDRESSED** | **MEDICATIONS** | **DOSAGE** |
|---|---|---|
| | | |
| | | |
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| | | |
| | | |
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| | | |

| **LIST ALL DOCTORS, THERAPISTS, OR OTHER HEALTH CARE PROVIDERS WITH WHOM YOU HAVE PREVIOUSLY CONSULTED ABOUT YOUR PROBLEM WITH ADDRESS AND PHONE NUMBER** | | |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |

| **ALLERGIES** | | |
|---|---|---|
| ☐ Yes ☐ N/A | Aspirin | **OTHER ALLERGIES** |
| ☐ Yes ☐ N/A | Codeine | |
| ☐ Yes ☐ N/A | Dental Anesthetics | |
| ☐ Yes ☐ N/A | Erythromycin | |
| ☐ Yes ☐ N/A | Jewelry | |
| ☐ Yes ☐ N/A | Latex | |
| ☐ Yes ☐ N/A | Metals | |
| ☐ Yes ☐ N/A | Penicillin | |
| ☐ Yes ☐ N/A | Tetracycline | |

# MEDICAL ALERTS

| | | | | | |
|---|---|---|---|---|---|
| ☐ Yes ☐ N/A | ABNORMAL BLEEDING | ☐ Yes ☐ N/A | HAY FEVER | ☐ Yes ☐ N/A | SICKLE CELL DISEASE |
| ☐ Yes ☐ N/A | ALCOHOL ABUSE | ☐ Yes ☐ N/A | HEART ATTACK | ☐ Yes ☐ N/A | SINUS PROBLEMS |
| ☐ Yes ☐ N/A | ALLERGIES | ☐ Yes ☐ N/A | HEART SURGERY | ☐ Yes ☐ N/A | STROKE |
| ☐ Yes ☐ N/A | ANEMIA | ☐ Yes ☐ N/A | HEMOPHILIA | ☐ Yes ☐ N/A | THYROID PROBLEMS |
| ☐ Yes ☐ N/A | ANGENIA PECTORIS | ☐ Yes ☐ N/A | HEPATITIS A | ☐ Yes ☐ N/A | TUBERCULOSIS |
| ☐ Yes ☐ N/A | ARTHRITIS | ☐ Yes ☐ N/A | HEPATITIS B | ☐ Yes ☐ N/A | ULCERS |
| ☐ Yes ☐ N/A | ARTIFICIAL BONES | ☐ Yes ☐ N/A | HIGH BLOOD PRESSURE | ☐ Yes ☐ N/A | YELLOW JAUNDICE |
| ☐ Yes ☐ N/A | ARTIFICIAL HEART VALVE | ☐ Yes ☐ N/A | JOINT REPLACEMENT | ☐ Yes ☐ N/A | BIRTH CONTROL? |
| ☐ Yes ☐ N/A | ASTHMA | ☐ Yes ☐ N/A | KIDNEY PROBLEMS | ☐ Yes ☐ N/A | PREGNANT? |
| ☐ Yes ☐ N/A | CANCER-CHEMOTHERAPY | ☐ Yes ☐ N/A | LIVER DISEASE | ☐ Yes ☐ N/A | NURSING? |
| ☐ Yes ☐ N/A | COLITIS | ☐ Yes ☐ N/A | LOW BLOOD PRESSURE | ☐ Yes ☐ N/A | TOBACCO? |
| ☐ Yes ☐ N/A | CONGENITAL HEART DEFECT | ☐ Yes ☐ N/A | MITRAL VALVE PROPLAPSE | ☐ Yes ☐ N/A | SMOKE? |
| ☐ Yes ☐ N/A | DIABETES | ☐ Yes ☐ N/A | PACE MAKER | ☐ Yes ☐ N/A | |
| ☐ Yes ☐ N/A | DIFFICULTY BREATHING | ☐ Yes ☐ N/A | PNEUMOCYSTITIS | ☐ Yes ☐ N/A | |
| ☐ Yes ☐ N/A | DRUG ABUSE | ☐ Yes ☐ N/A | PSYCHIATRIC PROBLEMS | ☐ Yes ☐ N/A | |
| ☐ Yes ☐ N/A | EMPHYSEMA | ☐ Yes ☐ N/A | RADIATION THERAPY | ☐ Yes ☐ N/A | |
| ☐ Yes ☐ N/A | EPILEPSY | ☐ Yes ☐ N/A | RHEUMATIC FEVER | ☐ Yes ☐ N/A | |
| ☐ Yes ☐ N/A | FAINTING SPELLS | ☐ Yes ☐ N/A | STD | ☐ Yes ☐ N/A | |
| ☐ Yes ☐ N/A | FEVER BLISTER | ☐ Yes ☐ N/A | SEIZURES | ☐ Yes ☐ N/A | |
| ☐ Yes ☐ N/A | HIV+ AIDS | ☐ Yes ☐ N/A | SHINGLES | ☐ Yes ☐ N/A | |

# DENTAL HISTORY AND INTERVIEW

**(PLEASE ANSWER AS COMPLETELY AS POSSIBLE)**

1. PLEASE LIST (IN ORDER) THE AREAS OF YOUR MOUTH THAT CONCERN YOU TODAY.

   _____

   _____

2. HOW LONG SINCE YOUR LAST DENTAL TREATMENT? _____
3. WERE YOU SEEING A DENTIST REGULARLY BEFORE THAT? _____
4. WHAT HAS BEEN YOUR EXPERIENCE WITH PREVIOUS DENTAL CARE?

   _____

5. DO YOU HAVE CONCERNS ABOUT FUTURE DENTAL CARE?

   _____

6. HOW LONG SINCE YOUR LAST FULL MOUTH X-RAYS (MORE THAN 4 FILMS)?

   _____

7. DO YOU FEEL YOUR MOUTH IS HEALTHY? _____
8. HAVE YOU EVER HAD A LOCAL ANESTHETIC LIKE NOVACAINE? _____
9. HAVE YOU HAD ANY UNFAVORABLE REACTIONS TO A LOCAL ANESTHETIC?

   _____

10. HAVE YOU HAD NITROUS OXIDE SEDATION BEFORE? _____
11. DO YOUR GUMS BLEED WHEN YOU CLEAN YOUR MOUTH? _____
12. ARE YOU AWARE THAT YOU CLENCH OR GRIND YOUR TEETH? _____
13. DO YOU EVER HAVE PAIN NEAR YOUR EARS OR FIND IT HARD TO MOVE YOUR JAW?

    _____

14. HAVE YOU HAD ANY TEETH REMOVED, AND IF SO, FOR WHAT REASON?

    _____

15. ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH?

    _____

16. HAVE YOU HAD ORTHODONTIC TREATMENT, AND IF SO, WHO WAS YOUR ORTHODONTIST? _____

# Notice of Privacy

As a provider of medical services we are required, under the Health Insurance Portability and Accountability Act, to inform you of your rights to protect your personal health information. As a covered entity, we must inform all patients of their rights regardless of insurance coverage.

## OUR DUTY TO YOU

As your dental provider we will do everything within our control to maintain your records and information in a secure and private manner. We do reserve the right to change our policies, but you will be informed of any changes in advance. We will only release information, about you and your treatment under specific circumstances. These include, but are not limited to the following:

**Treatment:** We may use your information during the course of treatment. This includes releasing information to other dentists, physicians, other health care providers, and our staff. Our staff includes full and part time employees, as well as, temporary personnel.

**Payment:** We may disclose personal information about you and your treatment to third party carriers and payment processing entities. This includes insurance carriers, claims clearinghouses, collection agencies, and third party administrators such as employee medical reimbursement accounts.

**Operations:** We may use your personal information in the course of operations of our office. This may include quality assurance/quality improvement reviews, credentialing, training, and certification and accreditation activities.

**Miscellaneous Uses:** At certain times we may be required to use your information for other purposes than as described above. Examples of these uses include: appointment reminders (cards, voice messages and letter), abuse/neglect, national security, family and friends (only to the extent for use in healthcare operations or payment), and in some cases to law enforcement and court ordered releases.

## YOUR RIGHTS

**Restrictions:** You have the right to restrict to request restrictions or disclosure usage. We are not required to accept these restrictions but we will make a note of the request and honor that request if applicable.

**Access:** You have the right to access your personal health information. A request for access must be made in writing. You may speak to our privacy officer to schedule an appointment to view your information. You may also request a copy of your personal health information. We will charge you a fee for the copies as set by the Texas State Board of Dental Examiners.

**Amendment:** You have the right to request that we amend your personal health information. Your request must be in writing and explain what should be amended and the rationale for such request. We have the right to deny this request if we feel that it would render your information inaccurate. We will inform you of the decision to amend your information.

**Disclosures:** You have the right to request a list of the times and entities to whom we have disclosed your personal health information. These disclosures are only for instances other than treatment, payment or operations. This disclosure will be given free on an annual basis if requested. We reserve the right to charge for this if requested more than once in a 12 month period.

**Complaints:** Please contact our privacy officer for any questions or complaints. If you feel that we have violated your privacy you submit a written complaint U.S.Department of Health and Human Services. We can provide you with the address upon request.

# Acknowledgement of Receipt
# Notice of Privacy Practices

By signing below I acknowledge that I have received or reviewed the Notice of Privacy. I agree with the terms of this notice and understand my rights under this notice. **By signing below I consent for the use of my personal health information for treatment, payment, and operations and other uses as described in the privacy notice.** I also understand that I have the right not to sign this agreement.

Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____

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If we are unable to get your acknowledgement then our office will make a notation as to the reason why it was not obtained.

Reason why acknowledgement was not obtained:

_____

_____

_____

Staff Name:_____

Signature:_____

Date:_____