PLEASE PRINT

# CONFIDENTIAL INFORMATION QUESTIONNAIRE

| PATIENT'S LEGAL NAME LAST FIRST MI | DATE OF BIRTH | SEX | SSN(US) / SIN(CAN) |
|---|---|---|---|

| PREFER TO BE CALLED | HOME PHONE # | CELL PHONE # |
|---|---|---|

| PATIENT'S ADDRESS STREET APT# CITY STATE ZIP/POSTAL CODE | E-MAIL |
|---|---|

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

| WORK ADDRESS STREET APT# CITY STATE ZIP/POSTAL CODE | WORK PHONE # |
|---|---|

| SPOUSE'S NAME LAST FIRST MI | SPOUSE'S EMPLOYER | OCCUPATION |
|---|---|---|

| SPOUSE'S WORK ADDRESS STREET APT# CITY STATE ZIP/POSTAL CODE | WORK PHONE # |
|---|---|

| OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE | WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE? |
|---|---|

# EMERGENCY CONTACT INFORMATION

## PERSON WE MAY CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)

| NAME | RELATIONSHIP |
|---|---|

| HOME PHONE # | WORK PHONE # | CELL PHONE # |
|---|---|---|

# REQUEST FOR CONFIDENTIAL COMMUNICATION

## AS MY DENTAL CARE PROVIDER, YOU MAY DO THE FOLLOWING WITH MY PERMISSION:

| | YES | NO |
|---|---|---|
| Contact me at home | ☐ | ☐ |
| Contact me via cell phone | ☐ | ☐ |
| Contact me at work | ☐ | ☐ |
| Contact me via e-mail | ☐ | ☐ |
| Leave messages on my home voicemail | ☐ | ☐ |
| Leave messages on my cell phone voicemail | ☐ | ☐ |
| Leave messages on my work voicemail | ☐ | ☐ |

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PLEASE PRINT

# INSURANCE AND FINANCIAL INFORMATION

| INSURANCE COVERAGE ☐ YES ☐ NO | INSURANCE COMPANY NAME | INSURANCE ADDRESS | | INSURANCE PHONE |
|---|---|---|---|---|
| SUBSCRIBER'S NAME | PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT | | SUBSCRIBER'S BIRTHDAY | SSN(US) / SIN(CAN) |
| GROUP / PROGRAM NUMBER | EMPLOYER (IF DIFFERENT FROM ABOVE) | | EMPLOYER'S ADDRESS | |

| SECONDARY COVERAGE ☐ YES ☐ NO | INSURANCE COMPANY NAME | INSURANCE ADDRESS | | INSURANCE PHONE |
|---|---|---|---|---|
| SUBSCRIBER'S NAME | PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT | | SUBSCRIBER'S BIRTHDAY | SSN(US) / SIN(CA) |
| GROUP / PROGRAM NUMBER | EMPLOYER (IF DIFFERENT FROM ABOVE) | | EMPLOYER'S ADDRESS | |

# RELEASE INFORMATION

## YOU MAY DISCUSS MY HEALTHCARE WITH

| | YES | NO |
|---|---|---|
| Health Care Providers | ☐ | ☐ |
| Insurance Companies | ☐ | ☐ |

**OTHERS (PLEASE PRINT)**

1.

2.

# CONFIRMATIONS

## DO YOU PREFER A CONFIRMATION CALL

☐ No, it is unnecessary ☐ Yes, it is a helpful reminder

# ASSIGNMENT & RELEASE

I hereby authorize (1) any available insurance benefits to be paid directly to my dentist, (2) the release of my dental health care information for any of my dental health care insurance claim, (3) the use of my dental records by my dentist in any professional manner that he/she determines, (4) the making of videotapes, photographs, and x-rays of my dental care treatment (collectively "My Images"), and (5) my dentist's use of My Images in scientific papers, demonstrations and/or presentations without compensation to me. I understand Hartrick Dentistry is out-of-network with all insurance plans.I agree that to the extent the cost of the dental care provided by my dentist is not covered by insurance, I am obligated to pay him/her such uninsured cost (the "Uninsured Costs") in accordance with his/her payment terms and policies. Finally, I certify that I have read or had read to me the contents of this form and understand the risks and limitations involved with the dental treatment that I am to receive.

| SIGNATURE - PATIENT / GUARDIAN | DATE |
|---|---|
| WITNESS SIGNATURE | DATE |

If the above named Patient is a minor or unable to pay the his/her Uninsured Costs, the undersigned agrees to guaranty the payment of such Uninsured Costs to the Patient's dentist in accordance with his/her payment terms and policies.

| SIGNATURE - GUARANTOR OF PATIENT | DATE |
|---|---|

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# 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

1. hospitalization for illness or injury ______
2. an allergic or bad reaction to any of the following:
   - aspirin, ibuprofen, acetaminophen, codeine ______
   - penicillin ______
   - erythromycin ______
   - tetracycline ______
   - sulfa ______
   - local anesthetic ______
   - fluoride ______
   - chlorhexidine (CHX) ______
   - Iodine ______
   - metals (nickel, gold, silver, ______ )
   - latex ______
   - nuts ______
   - fruit ______
   - milk ______
   - red dye ______
   - other ______
3. heart problems, or cardiac stent within the last six months ______
4. history of infective endocarditis ______
5. artificial heart valve, repaired heart defect (PFO) ______
6. pacemaker or implantable defibrillator ______
7. orthopedic or soft tissue implant (e.g joint replacement, breast implant) ______
8. heart murmur, rheumatic or scarlet fever ______
9. high or low blood pressure ______
10. a stroke (taking blood thinners) ______
11. anemia or other blood disorder ______
12. prolonged bleeding due to a slight cut (or INR > 3.5) ______
13. pneumonia, emphysema, shortness of breath, sarcoidosis ______
14. chronic ear infections, tuberculosis, measles, chicken pox ______
15. breathing problems (e.g. asthma, stuffy nose, sinus congestion) ______
16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) ______
17. kidney disease ______
18. liver disease or jaundice ______
19. vertigo (e.g. "the room is spinning") ______
20. thyroid, parathyroid disease, or calcium deficiency ______
21. hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome) ______
22. high cholesterol or taking statin drugs ______
23. diabetes (HbA1c = ______ ) ______
24. stomach or duodenal ulcer ______
25. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) ______
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) ______
27. arthritis or gout ______
28. autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) ______
29. glaucoma ______
30. contact lenses ______
31. head or neck injuries ______
32. epilepsy, convulsions (seizures) ______
33. neurologic disorders (e.g. Alzheimer's disease, dementia, prion disease) ______
34. viral infections and cold sores ______
35. any lumps or swelling in the mouth ______
36. hives, skin rash, hay fever ______
37. STI/STD/HPV ______
38. hepatitis (type ____ ) ______
39. HIV/AIDS ______
40. tumor, abnormal growth ______
41. radiation therapy ______
42. chemotherapy, immunosuppressive medication ______
43. emotional difficulties ______
44. psychiatric treatment or antidepressant medication ______
45. concentration problems or ADD/ADHD ______
46. alcohol/recreational drug use ______

## ARE YOU: YES NO

47. presently being treated for any other illness ______
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) ______
49. taking medication for weight management ______
50. taking dietary supplements, vitamins, and/or probiotics ______
51. often exhausted or fatigued ______
52. experiencing frequent headaches or chronic pain ______
53. a smoker, smoked previously or other (e.g. smokeless tobacco, vaping, e-cigarettes, and cannabis) ______
54. considered a touchy/sensitive person ______
55. often unhappy or depressed ______
56. taking birth control pills ______
57. currently pregnant ______
58. diagnosed with a prostate disorder ______

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) ______________________________

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

| Drug | Purpose | Drug | Purpose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**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 __________

**ASA ______ (1-6)**

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# DENTAL HISTORY

Patient 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:

### PERSONAL HISTORY — YES NO

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, and at what age? ______
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? ______

### GUM AND BONE — YES NO

7. Do your gums bleed sometimes or are they ever painful when brushing or flossing? ______
8. Have you ever been treated for gum disease, had scaling and root planing, or been told you have lost bone around your teeth? ______
9. Have you ever noticed an unpleasant taste or odor in your mouth? ______
10. Is there anyone with a history of periodontal disease in your family? ______
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth? ______
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ______
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? ______

### TOOTH STRUCTURE — YES NO

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

### BITE AND JAW JOINT — YES NO

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ______
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? ______
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ______
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? ______
25. Are your teeth becoming more crooked, crowded, or overlapped? ______
26. Are your teeth developing spaces or becoming more loose? ______
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? ______
28. Do you place your tongue between your teeth or close your teeth against your tongue? ______
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ______
30. Do you clench or grind your teeth together in the daytime or make them sore? ______
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? ______
32. Do you wear or have you ever worn a bite appliance? ______

### SMILE CHARACTERISTICS — YES NO

33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)? ______
34. Have you ever bleached (whitened) your teeth? ______
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? ______
36. Have you been disappointed with the appearance of previous dental work? ______

Patient's Signature ______________________ Date ________

Doctor's Signature ______________________ Date ________

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# LAMBERG QUESTIONNAIRE Version 6.0

*Correlating Sleep Quality & Health*

### 1: STANDARD QUESTIONS

- ☐ Do you awaken unrefreshed or feel sleepy during the day due to restless sleep?
- ☐ Is your snoring loud enough to disturb others?
- ☐ Have you been aware of your snoring for a long time?
- ☐ Have you been told your breathing stops while asleep?
- ☐ Do you ever wake yourself from sleep feeling that you are choking?
- ☐ Have you ever had a sleep study?
- ☐ Have you tried CPAP? (was the pressure > 10.5 cm? Y/N)
- ☐ Is your BMI > 27? Or is your neck size > 17 men, or > 15.5 women?

### 2: CARDIOLOGY & VASCULAR

- ☐ Do you have high blood pressure or take medicine for hypertension?
- ☐ Have you been diagnosed with: CAD, Stroke, Congestive Heart Failure, A Fib, or other health issues?
- ☐ Do you have a pacemaker?
- ☐ Do you have elevated total cholesterol levels?

### 3: PULMONOLOGY

- ☐ Have you experienced difficulty breathing during the day?
- ☐ Do you have shortness of breath, even with mild exertion?
- ☐ Have you been diagnosed with COPD or Asthma? Is Asthma worse at night?
- ☐ Do you have a chronic cough, either dry or productive?

### 4: GASTROENTEROLOGY

- ☐ Do you experience heartburn or acid reflux at night or in the morning?
- ☐ Have you or your dentist noticed erosion on molars?
- ☐ Do you take heartburn medications, either prescription or over the counter?

### 5: NEUROLOGY

- ☐ Do you experience numbness, tingling or pain in your feet or hands or head?
- ☐ Do you ever experience muscle weakness or dizziness or difficulty with coordination?

### 6: ENDOCRINOLOGY

- ☐ Have you been diagnosed with diabetes or hypothyroidism?
- ☐ Have you unexpectedly gained or lost weight lately?
- ☐ Have you gone through menopause? Are you on HRT?
- ☐ Do you experience repetitive limb movements or jerks in sleep, urges to move legs, or night sweats?

### 7: OTOLARYNGOLOGY

- ☐ Do you have difficulty breathing through your nose?
- ☐ Do you experience a dry mouth upon awakening?
- ☐ Do you have allergies that make nasal breathing difficult?
- ☐ Is post nasal drip a frequent problem?

### 8: UROLOGY

- ☐ Do you experience erectile dysfunction?
- ☐ Experience decreased interest in sex or have you taken medications to enhance sexual performance?
- ☐ Do you ever leak urine involuntarily?
- ☐ Do you have to urinate several times at night, or have you been diagnosed with BPH?

### 9: DENTAL (BRUXISM, TMD, PERIODONTICS, ORTHODONTICS)

- ☐ Do you grind your teeth while sleeping? Do your front teeth have a worn look?
- ☐ Have you had jaw muscles or joint pain, ringing in your ears, vertigo, or dizziness?
- ☐ Have you been diagnosed with periodontitis (gum disease)?
- ☐ Are your teeth very crowded or crooked?

### 10: PSYCHOLOGY & PSYCHIATRY

- ☐ Are you irritable upon waking in the morning?
- ☐ Do you experience insomnia? (either falling asleep or maintaining sleep)
- ☐ Do you experience: depression, PTSD, memory or concentration problems?
- ☐ Do you take medications for any of these conditions?

### 11: RHEUMATOLOGY

- ☐ Have you ever been diagnosed with Gout?
- ☐ Have you ever been diagnosed with Rheumatoid Arthritis?

### 12: CHRONIC PAIN

- ☐ Do you often wake up with headaches or have chronic headaches?
- ☐ Do you experience any chronic pain anywhere in your body?
- ☐ Do you take medications for pain on a daily basis?

### 13: PEDIATRICS (EXCLUDE FROM SCORING)

- ☐ Do you know any children who are mouth breathers, or who make any sleep breathing sounds?
- ☐ Do you know any children with bedwetting problems?

**TOTAL SCORE:** ________________

**Suspicion Level (Items Checked):**

**1 LOW  2-3 MODERATE  4+ HIGH**

**Name:**________________________________________ **Date:**__________________

## HIPAA OMNIBUS RULE

# PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: ________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
**MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

______________________________ ______________________________

Please ***print*** name of Patient — Please ***sign*** for Patient / Guardian of Patient

______________________________ ______________________________

Legal Representative / Guardian — Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: ______________________________

______________________________________________________________________

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Surname ☐ Other ________________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: ________________________ Relationship: ___________________________

Name: ________________________ Relationship: ___________________________

---

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message ☐ **Any of the Above**
☐ Text Message ☐ **None of the above** (opt out)
☐ Email

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

---

**Office Use Only**
As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) ____ ______________________________

Signature of Privacy Officer

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