PROGRESSIVE DENTAL CARE

CONFIDENTIAL INFORMATION QUESTIONNAIRE

Patient's Name Last First Mi Mr. Mrs. Ms. Dr. | I Prefer To Be Called | Date Of Birth | Age

Social Security # | If Child: Parent/Guardian's Name | Parent/Guardian's DOB | Parent/Guardian's SS# | Patient's Marital Status M S D W Under Age 18

Patient's Address Street Apt# City State Zip | Home Phone

E-mail | Cell Phone | Work Phone | OK To Call Work? Yes No Emergency Only

Patient's/Guardian's Employer | Occupation

Work Address Street City State Zip

Spouse's Name Last First Mi Mr. Mrs. Ms. Dr. | Spouse's Employer | Spouse's Occupation

Spouse's Work Address Street City State Zip | Cell Phone | Work Phone | OK To Call? Yes No Emergency Only

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 | Whom May We Thank For Referring You To Our Office?

INSURANCE AND FINANCIAL INFORMATION

Dental Insurance Coverage Yes No | Insurance Company Name | Address | Phone

Subscriber's Name | Patient's Relationship To Subscriber Self Spouse Dependent Other | Subscriber's Date of Birth | Subscriber's SS# or ID#

Group / Program Number | Employer | Employer Address

Secondary Dental Insurance Coverage Yes No | Insurance Company Name | Address | Phone

Subscriber's Name | Patient's Relationship To Subscriber Self Spouse Dependent Other | Subscriber's Date of Birth | Subscriber's SS# or ID#

Group / Program Number | Employer | Employer Address

Assignment & Release:

I hereby authorize my insurance benefits to be paid to Progressive Dental Care, Inc. I am financially responsible for any balances due and authorize Progressive Dental Care, Inc. 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 certify that I read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature of Parent/Guardian _____ Date _____

PROGRESSIVE DENTAL CARE

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
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? Scale of 1 to 10 (very) _____	☐	☐
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 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 to change? _____	☐	☐
8. Have you ever whitened (bleached) your teeth? _____	☐	☐
9. Are you self conscious about your teeth? _____	☐	☐
10. Have you been disappointed with the appearance of previous dental work? _____	☐	☐
BITE AND JAW JOINT ☐☐☐		
11. Do you / would you have any problems chewing gum? _____	☐	☐
12. Do you / would you have any problems chewing bagels or other hard foods? _____	☐	☐
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____	☐	☐
14. Are your teeth crowding or developing spaces? _____	☐	☐
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? _____	☐	☐
16. Do you have any problems with sleep or wake up with an awareness of your teeth? _____	☐	☐
17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
18. Do you have tension headaches or sore teeth? _____	☐	☐
19. Do you wear or have you ever worn a bite appliance? _____	☐	☐
TOOTH STRUCTURE ☐☐☐		
20. Have you had any cavities within the past 3 years? _____	☐	☐
21. Do you have a dry mouth? _____	☐	☐
22. Are any teeth sensitive to hot, cold, biting or sweets? _____	☐	☐
23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? _____	☐	☐
24. Do you avoid brushing any part of your mouth? _____	☐	☐
25. Do you feel or notice any holes (i.e. pitting) in your teeth? _____	☐	☐
GUM AND BONE ☐☐☐		
26. Have you ever been diagnosed or treated for periodontal (gum) disease? _____	☐	☐
27. Have you ever experienced gum recession? _____	☐	☐
28. Is there anyone with a history of periodontal disease in your family? _____	☐	☐
29. Do your gums bleed when brushing, flossing or eating? _____	☐	☐
30. Are your teeth becoming loose? _____	☐	☐
31. Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
32. Have you experienced a burning sensation in your mouth? _____	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

PROGRESSIVE DENTAL CARE

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

HAVE YOU EVER HAD THE FOLLOWING:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. allergic reaction to	☐	☐
☐ asprin, ibuprofen, acetaminophen	☐	☐
☐ penicilin	☐	☐
☐ erythromycin	☐	☐
☐ tetracycline	☐	☐
☐ codeine	☐	☐
☐ local anesthetic		
☐ fluoride		
☐ metals (gold, stainless steel)		
☐ latex		
☐ any other medications _____		
3. heart problems _____	☐	☐
4. heart murmur _____	☐	☐
5. rheumatic fever _____	☐	☐
6. scarlet fever _____	☐	☐
7. high blood pressure _____	☐	☐
8. low blood pressure _____	☐	☐
9. a stroke _____	☐	☐
10. artificial prosthesis (i.e. heart valve or joints) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut _____	☐	☐
13. emphysema _____	☐	☐
14. tuberculosis _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (il.e. snoring, sinus) _____	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid or parathyroid disease _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol _____	☐	☐
23. diabetes _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐

	YES	NO
25. digestive disorders (i.e. gastric reflux) _____	☐	☐
26. arthritis _____	☐	☐
27. glaucoma _____	☐	☐
28. contact lenses _____	☐	☐
29. head or neck injuries _____	☐	☐
30. epilepsy, convulsions (seizures) _____	☐	☐
31. neurologic problems _____	☐	☐
32. viral infections and cold sores _____	☐	☐
33. any lumps or swelling in the mouth _____	☐	☐
34. hives, skin rash, hay fever _____	☐	☐
35. venereal disease _____	☐	☐
36. heepatitis (type) _____	☐	☐
37. HIV / AIDS _____	☐	☐
38. tumor, abnormal growth _____	☐	☐
39. radiation therapy _____	☐	☐
40. chemotherapy _____	☐	☐
41. emotional problems _____	☐	☐
42. psychiatric treatment _____	☐	☐
43. antidepressant medication _____	☐	☐
44. alcohol/drug dependency _____	☐	☐
ARE YOU:		
45. presently being treated for any other illness _____	☐	☐
46. aware of a change in your general health _____	☐	☐
47. taking medication for osteoporosis/osteopenia _____	☐	☐
48. often exhausted or fatigued _____	☐	☐
49. subject to frequent headaches _____	☐	☐
50. a smoker or smoked previously _____	☐	☐
51. considered a touchy person _____	☐	☐
52. often unhappy or depressed _____	☐	☐
53. FEMALE - taking birth control pills _____	☐	☐
54. FEMALE - pregnant _____	☐	☐
55. MALE - prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List any 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 _____

PROGRESSIVE DENTAL CARE

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/13/03), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practice and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of you best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the heath information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page, $25.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. ***You must make your request in writing.*** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to hour health information or in response to a request you made to amend or restrict the use or disclosure of your health information , or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Jackie B. or Kathy D.

Telephone: (207) 773-1703

Fax: (207) 773-0258

Address: 192 Western Ave. South Portland, ME 04106

PROGRESSIVE DENTAL CARE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I, _____, have received a copy of this office's Notice of Privacy Practices.

Printed Name: _____

Signature: _____

Date: _____

For Office Use Only

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

- ☐ *Individual refused to sign*
- ☐ *Communications barriers prohibited obtaining the acknowledgement*
- ☐ *An emergency situation prevented us from obtaining acknowledgement*
- ☐ *Other (Please Specify):* _____

_____

PROGRESSIVE DENTAL CARE

AUTHORIZATION FOR PHOTOGRAPHY AND VIDEO PICTURES

I, _____, hereby consent that diagnostic photographs and/or video pictures can be taken of me by Progressive dental care, Inc., or any authorized agent of Progressive Dental Care, Inc. for any of the following purposes:

1. *For inclusion in my dental records.*
2. *For any purposes of accreditation, illustration, publication in dental journals, internet/web site information or for any other dental purpose deemed appropriate by my dentist.*
   (Note: Information for these purposes will not be released without your verbal notification and consent.)
3. *Law enforcement requests.*
4. *Educational purposes.*

Witness Name: _____ *Relationship :* _____

Signature: _____ *Date:* _____