GEORGETOWN DENTISTRY

2440 M St., NW, Suite 328, Washington, DC 20037 • T: 202-785-4141 • F: 202-688-1808
www.georgetowndentistry.com

CONFIDENTAL INFORMATION QUESTIONAIRE

Patient's Last Name | First Name | Middle Initial

Preferred Name / Nickname | (Responsible Party's Name, if not the patient) | (Relationship to Patient)

Patient Sex: ☐ Male ☐ Female

Date of Birth | SSN Number | Home or Cell Phone

Home Address | Work Phone

City | State | Zip | Email *(please be sure to write neatly)*

Name of Employer (or school) | Occupation (or field of study)

Employer's Address (or school address)

Marital Status: ☐ Married ☐ Unmarried ☐ Divorced ☐ Other_____

Full Name of Spouse | Spouse's Employer (Name & City)

Spouse's Work Phone

Who may we thank for referring you to our office?
(or please tell us how you heard about us)

Which other family members are patients at our office?

INSURANCE INFORMATION

Insurance Coverage: ☐ Yes ☐ No

Insurance Company Name | Primary Subscriber Name | Subscriber's DOB

Insurance Address | Patient's Relationship to Subscriber | Subscriber's Member ID

City | State | Zip | Insurance Provider Phone No. | Group ID

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact | Relationship to Patient

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? _____ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? _____ ☐ ☐
8. Have you ever been treated for gum decease or been told you 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 decease in your family? _____ ☐ ☐
11. Have you ever experienced gum recession? _____ ☐ ☐
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 sensation in your mouth? _____ ☐ ☐

TOOTH STRUCTURE

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 filing? _____ ☐ ☐
20. Do you frequently get food caught between any teeth? _____ ☐ ☐

BITE & JAW JOINT

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 bite your teeth together? _____ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ ☐ ☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____ ☐ ☐
26. Are your teeth developing spaces or becoming more loose? _____ ☐ ☐
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____ ☐ ☐
28. Do you place your tongue between your teeth or rest 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 your teeth in the daytime or make them sore? _____ ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness), 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

33. Is there anything about the appearance of your teeth that you would like to change? _____ ☐ ☐
34. Have you ever whitened (bleached) 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

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 reaction to:		
	☐ aspirin, ibuprofen, acetaminophen, codeine		
	☐ penicillin		
	☐ erythromycin		
	☐ tetracycline		
	☐ sulfa		
	☐ local anesthetic		
	☐ fluoride		
	☐ metals (nickel, gold, silver, _____)		
	☐ latex		
	☐ other _____		
3.	heart problems, or cardiac stint 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 implant (joint replacement) _____	☐	☐
8.	rheumatic or scarlet fever_____	☐	☐
9.	high or low blood pressure _____	☐	☐
10.	a stoke (taking blood thinners)_____	☐	☐
11.	anemia or other blood disorder _____	☐	☐
12.	prolonged bleeding due to a slight cut (INR.> 3.5) _____	☐	☐
13.	emphysema, shortness of breath, sarcoidosis _____	☐	☐
14.	tuberculosis, measles, chicken pox _____	☐	☐
15.	asthma_____	☐	☐
16.	breathing or sleep problems (i.e. sleep apnea, snoring, sinus) __	☐	☐
17.	kidney disease _____	☐	☐
18.	liver disease _____	☐	☐
19.	jaundice_____	☐	☐
20.	thyroid, parathyroid disease, or calcium deficiency_____	☐	☐
21.	hormone deficiency _____	☐	☐
22.	high cholesterol or taking statin drugs_____	☐	☐
23.	diabetes (HbA1c = _____) _____	☐	☐
24.	stomach or duodenal ulcer _____	☐	☐
25.	digestive disorders (i.e. celiac disease, gastric reflux) _____	☐	☐
26.	osteoporosis/osteoperia (i.e. taking bisphosphonates) _____	☐	☐

		YES	NO
27.	arthritis _____	☐	☐
28.	autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29.	glaucoma _____	☐	☐
30.	contact lenses_____	☐	☐
31.	head or neck injuries _____	☐	☐
32.	epilepsy, convulsions (seizures) _____	☐	☐
33.	neurologic disorders (ADD/ADHD, 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_____	☐	☐
45.	antidepressant medication_____	☐	☐
46.	alcohol / recreation drug use _____	☐	☐
	ARE YOU:		
47.	presently being treated for any other illness_____	☐	☐
48.	aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	☐	☐
49.	taking medication for weight management _____	☐	☐
50.	taking dietary supplements _____	☐	☐
51.	often exhausted or fatigued _____	☐	☐
52.	experiencing frequent headaches _____	☐	☐
53.	a smoker, smoked previously or used smokeless tobacco____	☐	☐
54.	considered a touchy / sensitive person _____	☐	☐
55.	often unhappy or depressed _____	☐	☐
56.	FEMALE - taking birth control pills_____	☐	☐
57.	FEMALE - pregnant_____	☐	☐
58.	MALE - prostate disorders_____	☐	☐

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, and or vitamins 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 _____

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HIPAA INFORMATION AND CONSENT FORM

The Health Insurance and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specially, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

WE HAVE ADOPTED THE FOLLOWING POLICIES

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information, which is not already a matter of public record. The normal course of providing care mean that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will be available to persons other than the office staff. You agree to the normal procedures utilized with the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to the office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents, which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring my concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purpose of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I,_____ date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

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OFFICE POLICY AND PATIENT CONSENT

Thank you for choosing our office for your dental needs. Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life-enhancing care. We are always available to answer your questions or assist you in any way we can.

We believe in the value of clear communication, as well as mutual understanding and respect. We believe that our patients would like to know and understand our appointment, financial, and insurance guidelines in advance of their treatment. You will find these guidelines outlined below, however we are always happy to discuss your proposed treatment and any of our practice guidelines with you personally.

PATIENT CONSENT

I authorize Dr. Roshankar and staff to provide any and all forms of treatment, medication and to take X-rays/Pictures before, during and after treatment that may be necessary or advisable in connection with my dental care, or for my dependent. I further consent to Dr. Roshankar and staff choosing and employing such methods and means as is deemed fit. I understand that prior to treatment, a full explanation of the procedure(s) involved will be given by Dr. Roshankar or staff, and I agree to ask any questions that I may have, or raise any issues, prior to the start of the treatment.

APPOINTMENT GUIDELINES

It is our desire to provide the highest-quality dental care and individual attention for you in a timely manner. We pre-plan and prepare for your visit and hope you have done the same. Your appointment time has been reserved especially for you and we strongly encourage all patients to keep their appointments. When time is lost due to last-minute appointment changes, other patients in need of treatment can not be seen and treatment is delayed. **Should any scheduling changes be required, we require at least 48 hours advance notice to avoid a $75.00 cancellation fee.**

We make every effort to remind patients by telephone or email prior to their appointment but please do not depend on this courtesy. We have found that with the recent popular use of answering machines, cell phones, and voicemail, some of our patients are not receiving these reminder calls. It is always helpful, if you use such devices, for you to return our call to confirm that you have received our message. **If we are unable to contact you directly, your appointment card or your appointment phone call will serve as confirmation of your appointment and implies your obligation to be present at the prearranged date and time.**

FINANCIAL GUIDELINES

New Patients: All treatment rendered on the first visit must be paid in full at the time of service. We happily accept cash, personal checks, and credit cards (MasterCard, Visa, American Express, and Discover).

Returning Patients: All of our fees or co-pays less than $500.00 will be due and payable at the time treatment is rendered. For fees and co-pays over $500.00, we have several financial options available.

INSURANCE GUIDELINES

We provide services for our patients with the understanding that they are responsible for payment in accordance with our financial policy. Please know that we will do everything possible to see that you receive the full benefits of your insurance policy. Dental insurance is different than most medical insurance plans and it is important to be aware of the following:

- **Insurance is an agreement between you and your insurance company:** The insurance relationship constitutes an agreement between the insurance carrier, the employer and the patient. Our dental office is not a party to this contract. As such, we can make no guarantee of estimated coverage or payment.

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GEORGETOWN DENTISTRY

INSURANCE GUIDELINES *continued*

- **All dental fees are not always covered:** Insurance companies base the amounts they pay on restrictive fee schedules, regardless of what the actual fee may be.
- **Some dental procedures may not be covered:** Not all dental services that are necessary for excellent dental health are covered benefits in all contracts. This depends on the kind of plan your employer has purchased.
- **Here's What We Promise to Do:**
  1. Complete Insurance claim forms and submit to your carrier within 24 hours of treatment.
  2. Use current American Dental Association coding for correct reporting of procedures.
  3. If necessary, re-file your insurance a second time within a 30-60 day period.
- **Your Responsibilities Will be to:**
  1. Pay our fees at the time of treatment or as otherwise arranged in advance.
  2. Provide our office with necessary information concerning your insurance coverage to allow correct filing of claims.
  3. Understand that your plan is a contract between you, your employer and the insurance carrier. Our office will do all we can to facilitate claims payment, but we do not have the power to force your insurance company to pay.
  4. Understand your insurance benefits and frequency limitations.

PAYMENT OPTIONS

1. **Pre-payment Cash Courtesy:**
   We are happy to offer a 5% accounting courtesy for all treatment over $1000.00 that is paid in cash prior to treatment commencing.
2. **Payment as Service is Rendered:**
   If you wish to pay the estimated amount for treatment not covered by insurance at the time services are rendered.
3. **For Patients with Dental Insurance:**
   We will prepare and submit forms and reports to assist you in obtaining maximum benefits available. Your dental benefits are a contract between you, your employer and the insurance company, therefore we do not confirm insurance eligibility or pre-determine recommended treatment.

Monthly Payment Plans:

a. "Same as Cash" Interest-Free Credit Line: We offer a monthly payment plan (up to 12 months) interest free through CareCredit. CareCredit offers an easy three-step process to get instant credit approval for your dental care needs. Care Credit is a GE Money Company that has been offering credit for medical care for more than 20 years. You can apply at our office or for more information visit carecredit.com.

In consideration to the services rendered to me by Georgetown Dentistry I am obligated to pay said office in accordance with its financial terms and policy. I consent that I am financially responsible for any balances due and authorize Georgetown Dentistry to release my information to the insurance carrier for payment of the insurance benefits payable to me.

I certify that I have read or had read to me the content of this form and also realize the risks and limitations involved

SIGNATURE _____ DATE _____

DENTAL OFFICE REPRESENTATIVE: _____ DATE _____