



PLEASE PRINT

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S LEGAL NAME LAST		FIRST		MI	DATE OF BIRTH	SEX	SSN
PREFER TO BE CALLED				HOME PHONE		CELL PHONE	
PATIENT'S ADDRESS STREET		APT #	CITY	STATE	ZIP/POSTAL CODE	E-MAIL	
MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> UNDER AGE 18		PATIENT'S/GUARDIAN'S EMPLOYER				OCCUPATION	
WORK ADDRESS STREET		APT #	CITY	STATE	ZIP/POSTAL CODE	WORK PHONE	
SPOUSE/GUARDIAN LAST		FIRST		MI	SPOUSE/GUARDIAN EMPLOYER		OCCUPATION
SPOUSE'S WORK ADDRESS STREET		APT #	CITY	STATE	ZIP/POSTAL CODE	WORK PHONE	
OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE					WHOM 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

Methods of Communication

Unless you indicate a preference to **not** be contacted by a method, our office utilizes multiple methods of communication with our patients.

REQUEST FOR CONFIDENTIAL COMMUNICATION

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

	YES	NO
Contact me at home/Leave messages on my home voicemail	<input type="radio"/>	<input type="radio"/>
Contact me via cell phone/Leave messages on my cell phone voicemail	<input type="radio"/>	<input type="radio"/>
Contact me via e-mail	<input type="radio"/>	<input type="radio"/>

CONFIRMATIONS

DO YOU PREFER A CONFIRMATION CALL



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

_____ I provide Tampa Bay Periodontics and Implant Dentistry and their staff consent to discuss limited Personal Health Information with anyone who transports me to and from an appointment when I am sedated. Examples might include how your treatment went or instructions for any post-treatment care.

initials



PLEASE PRINT

DENTAL INSURANCE & FINANCIAL INFORMATION

INSURANCE COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT	SUBSCRIBER'S BIRTH DATE	SSN
GROUP/PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)		EMPLOYER'S ADDRESS
SECONDARY COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT	SUBSCRIBER'S BIRTH DATE	SSN
GROUP/PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)		EMPLOYER'S ADDRESS

RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTHCARE WITH

	YES	NO	OTHERS (PLEASE PRINT)
Health Care Providers	<input type="checkbox"/>	<input type="checkbox"/>	1.
Insurance Companies	<input type="checkbox"/>	<input type="checkbox"/>	2.

NOTICE OF PRIVACY PRACTICES

- _____ I have received a copy of the Notice of Privacy Practices of Tampa Bay Periodontics and Implant Dentistry. I hereby authorize, as indicated by my initials, Tampa Bay Periodontics and Implant Dentistry to use and disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the patient consent form.

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 in connection with any insurance claim for such care, (3) my dentist to use my dental records in any professional manner that he/she so determines, (4) the making of videotapes, photographs, and x-rays of the dental treatment that I receive before, during and after such treatment (collectively "My Images"), and (5) my dentist to use My Images in scientific papers, demonstrations and/or presentations without compensation to me. If I am signing this form as the guardian of a patient then the above authorization is on behalf of such patient.

I acknowledge and agree that if certain costs of my dental care are not covered by insurance, I am financially responsible and obligated to pay my dentist such uninsured cost in accordance with the payment terms and policies of my dentist. If I am signing this form as the guardian of the dentist's patient, the dentist agrees that my signature does not make me personally liable for the payment of any uninsured costs.

Finally, by signing below I acknowledge my understanding of the risks and limitations involved with the dental treatment that I am to receive or that the patient is to receive if I am signing as such patient's guardian.

SIGNATURE - PATIENT/GUARDIAN	DATE
WITNESS SIGNATURE	DATE



TAMPA BAY

PERIODONTICS AND IMPLANT DENTISTRY

James G. Wilson, DMD
Board Certified Periodontist
Matthew T. Waite, DDS, MS
Michael R. Tesmer, DMD, MS
Board Certified Periodontist

MEDICAL/DENTAL HISTORY

- Do you have or have you ever had: YES NO
- Hospitalization for illness or injury _____
 - An allergic reaction to
 - aspirin, ibuprofen, acetaminophen, codeine
 - penicillin erythromycin
 - tetracycline sulfa
 - local anesthetic fluoride
 - metals (nickel, gold, silver, _____)
 - latex
 - other _____
 Pharmacy Name: _____
 Pharmacy Address: _____
 Pharmacy Phone Number: _____
 Restorative Dentist: _____
 - Are you in good health? Yes No
 - Date of last physical examination _____ Are you currently being treated by a physician? ... Yes No
 Physician Name: _____ Physician Number: _____
 - Are you taking any prescription drugs or medications? Yes No
 If yes, please list _____
 - Are you taking any over-the-counter preparations or medications (example: aspirin, vitamins, supplements)? Yes No
 If yes, please list _____
 - Indicate which of the following you have had or have at the present:

Heart disease or attack . . . Yes <input type="checkbox"/> No <input type="checkbox"/>	Allergies or hives Yes <input type="checkbox"/> No <input type="checkbox"/>	Anemia Yes <input type="checkbox"/> No <input type="checkbox"/>
High blood pressure Yes <input type="checkbox"/> No <input type="checkbox"/>	Sinus trouble Yes <input type="checkbox"/> No <input type="checkbox"/>	Prolonged bleeding Yes <input type="checkbox"/> No <input type="checkbox"/>
Angina Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid disease Yes <input type="checkbox"/> No <input type="checkbox"/>	Hemophilia Yes <input type="checkbox"/> No <input type="checkbox"/>
Congenital heart lesions . . Yes <input type="checkbox"/> No <input type="checkbox"/>	Liver disorder Yes <input type="checkbox"/> No <input type="checkbox"/>	Immune system disorder Yes <input type="checkbox"/> No <input type="checkbox"/>
Artificial heart valve Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis Yes <input type="checkbox"/> No <input type="checkbox"/>	AIDS/HIV positive Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart pacemaker Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes Yes <input type="checkbox"/> No <input type="checkbox"/>	Fainting or dizziness Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart surgery Yes <input type="checkbox"/> No <input type="checkbox"/>	Hemoglobin A1c. _____	Epilepsy or seizures Yes <input type="checkbox"/> No <input type="checkbox"/>
Hip/Knee replacement . . . Yes <input type="checkbox"/> No <input type="checkbox"/>	Hypoglycemia Yes <input type="checkbox"/> No <input type="checkbox"/>	Cancer Yes <input type="checkbox"/> No <input type="checkbox"/>
Other joint replacement . . Yes <input type="checkbox"/> No <input type="checkbox"/>	Arthritis or rheumatism Yes <input type="checkbox"/> No <input type="checkbox"/>	Chemotherapy Yes <input type="checkbox"/> No <input type="checkbox"/>
Stroke Yes <input type="checkbox"/> No <input type="checkbox"/>	Osteoporosis Yes <input type="checkbox"/> No <input type="checkbox"/>	Radiation treatment Yes <input type="checkbox"/> No <input type="checkbox"/>
Kidney disorder Yes <input type="checkbox"/> No <input type="checkbox"/>	Glaucoma Yes <input type="checkbox"/> No <input type="checkbox"/>	Mental disorder Yes <input type="checkbox"/> No <input type="checkbox"/>
Ulcers Yes <input type="checkbox"/> No <input type="checkbox"/>	Cold sores/fever blisters Yes <input type="checkbox"/> No <input type="checkbox"/>	Anxiety Yes <input type="checkbox"/> No <input type="checkbox"/>
Emphysema Yes <input type="checkbox"/> No <input type="checkbox"/>	Venereal disease Yes <input type="checkbox"/> No <input type="checkbox"/>	Drug addiction Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma Yes <input type="checkbox"/> No <input type="checkbox"/>	Blood disease/disorder Yes <input type="checkbox"/> No <input type="checkbox"/>	Alcohol addiction Yes <input type="checkbox"/> No <input type="checkbox"/>
 - Do you have any disease, condition, or problem not listed? Yes No
 If yes, please explain _____
 - Do you currently or have you in the past taken Fosamax, Actonel, Boniva, Prolia or Reclast for osteoporosis/osteopenia or were you treated with the medications Zometa or Aredis for chemotherapy? Yes No
 - Do you currently smoke or use smokeless tobacco? Yes No
 - Have you previously smoked or used smokeless tobacco? Yes No
 - Date of last dental visit _____
 - Have you had any problems associated with previous dental treatment? Yes No
 - Have you ever had periodontal treatment? Yes No
 - Have you ever worn braces? Yes No
 - Do you clench or grind your teeth? Yes No
 - Do you experience pain in your jaw joints or facial muscles? Yes No
 - Do you wear any removable dental appliances? Yes No
 - Do you have any specific questions or concerns about your oral health? Yes No
 If yes, please explain _____

WOMEN

- Are you pregnant? Yes No
- Are you taking birth control pills? Yes No

SIGNATURE - PATIENT/GUARDIAN	DATE
PRINT - PATIENT NAME	
SIGNATURE - DOCTOR	DATE