CIGNO DENTAL CARE

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help.

Whom may we thank for referring you? ____

ABOUT THE PATIENT

Name: ______________________________ **I prefer to be called**__________________
[ ] Male [ ] Female **[ ] Single [ ] Married [ ] Child [ ] Other**
DOB: ____ /____/ ____ **Age:** ______ **S .S. #:** ______ - ____ - ______
Home Address: __________________________________ **City** ____________________
State ______ **Zip** _________
Home Phone: (____) ________________ **Work: (____)** _____________ **ext.** ______
Cell: (____) ____________ **E-mail Address:** ___________________________________
Employer: ____________________ **How long?** ________ **Occupation:** ____________
Employer's Address: ______________________ **City**______________ **State**_____ **Zip**______

PERSON RESPONSIBLE FOR ACCOUNT

[ ] Same as above

Name: ______________________ **Birth date:** ____ /____ / ____ **Relation:** ____________________
Billing Address:______________________ **City**_______________ **State** ________ **Zip** __________
Home Phone: (_____) ____________ **Work: (_____)** ________________ **S.S. #:** _____- _____ - ______
Employer: ______________________ **How long there?** _________ **Occupation:** _______________

SPOUSE/EMERGENCY CONTACT INFORMATION

Name: ______________________ **Relation:** ____________________ **DOB:** _____ /_____ /______
Employer: ________________**Work Phone: (____)** ____________ **Cell/Home #:**________________

DENTAL INSURANCE INFORMATION

Primary Dental Insurance
Insurance Co. Name: _________________ **Phone: (____)** __________**Group/Policy #:** ___________
Insured's Name: ________________ **Insured's Birth date:** ____/____/____ **Relation:** ____________
Insured's Social Security #/ID#: ____________________ **Insured's Employer:** _________________

Secondary Dental Insurance
Insurance Co. Name: _________________ **Phone: (_____)** __________ **Group/Policy #:** ___________
Insured's Name: ________________ **Insured's Birth date:** ____/____/_____ **Relation:** ___________
Insured's Social Security #/ID#: _____________________ **Insured's Employer:** _________________

Dental History

Do you have or have ever had any of the following? *Please check those that apply:*

Reason For today's Visit ____________________
Former Dentist ____________________________
Date of Last Dental Visit ____________________
How often do you brush? ___________________
How often do you floss? ___________________
[ ] Cigarette, Pipe, or Cigar Smoking

[ ] Bleeding Gums
[ ] Orthodontic Treatment
[ ] Sensitivity to cold or heat
[ ] Sensitivity to Sweets
[ ] Pain? Explain ___________________________
____

MEDICAL HISTORY INFORMATION

Name of Primary Care Physician: ___________________________ **Phone**: (____) ________________

Are you seeing a specialist for any reason? Please provide their information.

Name of Specialist: ________________________________ Phone: (_____) ____________________
Reason for seeing specialist: ____

Do you have or have ever had any of the following? *Please check those that apply*:

[ ] AIDS/HIV
[ ] Anemia
[ ] Arthritis / Rheumatism
[ ] Artificial Joints
Which Joint? ______________
When? ____________________
[ ] Artificial Heart Vales
[ ] Asthma
[ ] Back Problems
[ ] Bleeding abnormally, with extractions or surgery
[ ] Cancer, Type? ___________
[ ] Blood Disease, Type? ____________________
[ ] Drug Dependency
[ ] Chemotherapy
[ ] Circulatory Problems
[ ] Congenital Heart Lesion
[ ] Cortisone Treatments
[ ] Diabetes
[ ] Emphysema

[ ] Epilepsy or Seizures
Last Episode? ______________
[ ] Fainting or Dizziness
[ ] Heart murmur
[ ] Heart problems
Describe? _________________
[ ] Hepatitis, Type? __________
[ ] Herpes
[ ] High Blood Pressure
[ ] Jaundice
[ ] Jaw pain
[ ] Kidney disease
[ ] Liver disease
[ ] Low blood pressure
[ ] Mitral Valve Prolapse
[ ] Nervous problems
Describe? _________________
[ ] Pacemaker
[ ] Psychiatric Care
[ ] Osteoporosis

[ ] Radiation Treatment
[ ] Respiratory disease
[ ] Rheumatic Fever
[ ] Shortness of breath
[ ] Sinus trouble
[ ] Stroke
[ ] Thyroid Problems
[ ] Tonsillitis
[ ] Tuberculosis
[ ] Tumor or growth on Head or neck
[ ] Stomach/Intestinal Ulcers
[ ] Are you pregnant or Nursing?
[ ] Other
____
____
[ ] None of The Above Apply

Medications

List any medications you are currently taking and the correlating diagnosis:
____
____
____
____
____
____
[ ] If you have a list please provide so we may take a copy.
Doctors Signature _____________________________

Allergies

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa

Other ________________________________
Patient Signature _______________________

CUSTOMIZED PERSONALITY PROFILE

In order to serve you better and to give you the individual attention you deserve please check the appropriate responses.

I have a fear of / I have concerns about:

__ Experiencing pain
__ Not being numb
__ Needles
__ Unnecessary or wrong treatment
__ Gagging
__ Losing control
__ Having something put over my mouth
__ Being scolded or made to feel ashamed
__ Catching a disease
__ Losing my teeth
__ Having to wear a denture or partial
__ Other ___________________________________

When I think about coming to the dentist I feel:

__ **Comfortable** – I have no anxiety about seeing the dentist or dental procedures
__ **Anxious** –I don't want to come but I make myself, however I am seldom comfortable
__ **Fearful** – I have stayed away from the dentist because of my fear and avoid coming unless absolutely necessary
__ **Extremely Fearful** – I cannot cope with dental visits and have avoided the dentist for years to the detriment of my dental health

The following makes me uncomfortable:

__ The sounds of a dental drill
__ Laying down in a dental chair
__ The smells in a dental office
__ Being numb
__ Having to wait in the reception area
__ Other ______________________________

I have avoided the dentist because of:

__ Anxiety and Fear
__ Budget Concerns
__ Time Concerns
__ No Sense of Urgency
__ Lack of trust
__ Other _______________________________

To understand what's going on in my mouth my preference is:

__ To know all the details
__ To be given the bottom line
__ To be shown pictures and movies
__ To read pamphlets and brochures
__ To talk with a team member about solutions to my problems

My childhood dental experiences were:

__ Completely pain free and comfortable
__ Somewhat uncomfortable
__ Painful
__ Traumatic
__ I did not go to the dentist as a child

My immediate concern about my teeth and my smile is:

____
____
____
____

My dental experiences as an adult have been:

__ Completely pain free and comfortable
__ Somewhat comfortable
__ Painful
__ Traumatic
__ I have not seen the dentist as an adult or my visits have been very few

Appointment Alliance

As your dental family we value your time, and as such, you can expect that we will do everything possible to see you in a timely manner. We also reserve specific times in specific rooms for all of our patient's appointments Monday through Friday, and have appointment times that allow us to accommodate all of our patient's busy schedules. In return, we ask that you make every attempt to keep your reserved time by making us a priority on your calendar. For future appointments, depending on your appointment history, if you miss a reserved appointment or cancel less than 48 hours before a reserved appointment, you may be required to make a $50.00 cash or credit card deposit before another appointment can be reserved. For your convenience, we offer a texting and emailing service that will alert you of an upcoming appointment. We do ask that you confirm your appointment by either emailing or calling the office. For those who do not, we reserve the right to remove your appointment and give the time to someone else. Thank you in advance for your dedication to your dental health.

Financial Alliance

Also, as your dental health partner we offer many options to enable you to achieve your dental health goals. We offer complimentary insurance benefits checks, as well as accept assignment of benefits from the insurance company, if you have a dental plan. Our Business Coordinators will make every effort to help you to maximize your dental benefits. For your estimated portion, we offer many options for payment so you can choose the one that works best for your budget. Amongst these options are: cash or check, and we accept every major credit card. We also offer short term interest free, and long term low interest financing through CareCredit. We have an option to prepay your portion and receive a 5% discount. We also offer a maximum 10% discount for seniors who do not have dental insurance.

As a courtesy to you we will file your dental insurance (if you have it), however you are responsible for the entire balance. We will accept your estimated portion as payment, however any unpaid portions will be your responsibility.

Together, we can make it a team effort to help you achieve your dental health goals!

I have read and understand the above and accept responsibility for my portion of the alliances.

Signature_______________________________________ Date___________________________

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P A T I E N T C O N S E N T F O R M

The Department of Health and Human Services has established a “Privacy Policy” to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations. As our patient we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your healthcare information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest. We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patient), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

PRINT NAME: _____________________ SIGNATURE:_____________________ DATE:______

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:
The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the “Privacy Rule.” We strive to achieve the very highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate use of PHI ion accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes, in any way, to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate us of PHI. We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients