PLEASE PRINT

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S LEGAL NAME LAST, FIRST MI	DATE OF BIRTH	SEX	SOCIAL SECURITY #

PREFER TO BE CALLED	HOME PHONE #	CELL PHONE #

PATIENT'S ADDRESS STREET APT# CITY STATE ZIP	E-MAIL

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

WORK ADDRESS STREET APT# CITY STATE ZIP	WORK PHONE #

SPOUSE'S NAME LAST, FIRST MI	SPOUSE'S EMPLOYER	OCCUPATION

SPOUSE'S WORK ADDRESS STREET APT# CITY STATE ZIP	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 / answering machine	☐	☐
Leave messages on my cell phone voicemail	☐	☐
Leave messages on my work voicemail / answering machine	☐	☐

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	SUBSCRIBER'S SSN / ID #
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	SUBSCRIBER'S SSN / ID #
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	☐	☐	1.
Insurance Companies	☐	☐	2.

CONFIRMATIONS

DO YOU PREFER A CONFIRMATION CALL

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

ASSIGNMENT & RELEASE

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists 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 consent to making of videotapes, photographs, and x-rays before, during, and after treatment, and to use the same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

SIGNATURE - PATIENT / GUARDIAN	DATE
WITNESS 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		
	☐ sulpha		
	☐ local anesthetic		
	☐ fluoride		
	☐ metals (nickel, gold, silver, ______)		
	☐ latex		
	☐ 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.	artificial prosthesis (heart valve or joints) ______	☐	☐
8.	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 (INR > 3.5) ______	☐	☐
13.	emphysema, sarcoidosis ______	☐	☐
14.	tuberculosis ______	☐	☐
15.	asthma ______	☐	☐
16.	breathing or sleep problems (i.e. 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. gastric reflux) ______	☐	☐
26.	osteoporosis/osteopenia (i.e. taking bisphosphonates) ___	☐	☐
27.	arthritis ______	☐	☐
28.	glaucoma ______	☐	☐
29.	contact lenses ______	☐	☐
30.	head or neck injuries ______	☐	☐
31.	epilepsy, convulsions (seizures) ______	☐	☐
32.	neurologic problems (attention deficit disorder) ______	☐	☐
33.	viral infections and cold sores ______	☐	☐
34.	any lumps or swelling in the mouth ______	☐	☐
35.	hives, skin rash, hay fever ______	☐	☐
36.	venereal disease ______	☐	☐
37.	hepatitis (type ___) ______	☐	☐
38.	HIV / AIDS ______	☐	☐
39.	tumor, abnormal growth ______	☐	☐
40.	radiation therapy ______	☐	☐
41.	chemotherapy ______	☐	☐
42.	emotional problems ______	☐	☐
43.	psychiatric treatment ______	☐	☐
44.	antidepressant medication ______	☐	☐
45.	alcohol / drug dependency ______	☐	☐

ARE YOU:

		YES	NO
46.	presently being treated for any other illness ______	☐	☐
47.	aware of a change in your general health ______	☐	☐
48.	taking medication for weight management (i.e. fen-phen)	☐	☐
49.	taking dietary supplements ______	☐	☐
50.	often exhausted or fatigued ______	☐	☐
51.	subject to frequent headaches ______	☐	☐
52.	a smoker or smoked previously ______	☐	☐
53.	considered a touchy person ______	☐	☐
54.	often unhappy or depressed ______	☐	☐
55.	FEMALE - taking birth control pills ______	☐	☐
56.	FEMALE - pregnant ______	☐	☐
57.	MALE - prostate disorders ______	☐	☐

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

____

List all 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 ______________

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

		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? ________	☐	☐
6.	Have you had any teeth removed? ________	☐	☐

SMILE CHARACTERISTICS

		YES	NO
7.	Is there anything about the appearance of your teeth that you would like to change? ________	☐	☐
8.	Have you ever whitened (bleached) your teeth? ________	☐	☐
9.	Have you felt uncomfortable or self conscious about the appearance of your teeth? ________	☐	☐
10	Have you been disappointed with the appearance of previous dental work? ________	☐	☐

BITE AND JAW JOINT

		YES	NO
11.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ________	☐	☐
12.	Do you / would you have any problems chewing gum? ________	☐	☐
13.	Do you / would you have any problems chewing bagels, baguettes , protein bars, or other hard foods? ________	☐	☐
14.	Have your teeth changed in the last 5 years, become shorter, thinner or worn? ________	☐	☐
15.	Are your teeth crowding or developing spaces? ________	☐	☐
16.	Do you have more than one bite and squeeze to make your teeth fit together? ________	☐	☐
17.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ________	☐	☐
18.	Do you clench your teeth in the daytime or make them sore? ________	☐	☐
19.	Do you have any problems with sleep or wake up with an awareness of your teeth? ________	☐	☐
20.	Do you wear or have you ever worn a bite appliance? ________	☐	☐

TOOTH STRUCTURE

		YES	NO
21.	Have you had any cavities within the past 3 years? ________	☐	☐
22.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ________	☐	☐
23.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ________	☐	☐
24.	Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? ________	☐	☐
25.	Do you have grooves or notches on your teeth near the gum line? ________	☐	☐
26.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ________	☐	☐
27.	Do you get food caught between any teeth? ________	☐	☐

GUM AND BONE

		YES	NO
28.	Do your gums bleed when brushing or flossing? ________	☐	☐
29.	Have you ever been treated for gum disease or been told you have lost bone around your teeth? ________	☐	☐
30.	Have you ever noticed an unpleasant taste or odor in your mouth? ________	☐	☐
31.	Is there anyone with a history of periodontal disease in your family? ________	☐	☐
32.	Have you ever experienced gum recession? ________	☐	☐
33.	Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ________	☐	☐
34.	Have you experienced a burning sensation in your mouth? ________	☐	☐

Patient's Signature ______________________________ Date __________

Doctor's Signature ______________________________ Date __________

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Broomfield Family Dentistry
13605 Xavier Lane, Ste C
Broomfield, CO 80023
Office: (303)469-2016

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (NPP)

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT.

I. ______________________. have received a copy of Broomfield Family Practice Notice of Privacy Practices (NPP) either in paper form. laminated copy. downloaded and printed from another source, or viewed electronically on a personal computer. smart phone. etc.

____
Print Patient's Name

____
Signature of Patient or Parent/Guardian

____
Date

____
Name and Birthdate of individual we have permission to release information to:

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices (NPP). but acknowledgement could not be obtained because:

( ) Individual refused to sign

( ) Communication barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (Please Specify) ______________________

____

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

____

____

Signature:____________________________ Date:______________________

Appointment Reservation Agreement:

At Broomfield Family Dentistry we value our time with our patients and do our best to try to respect yours as well! We reserve at least 90 minutes of our provider's time exclusively for your initial visit. As being a new patient, we know your time is valuable to us and would like your first visit to run smooth as possible. We ask you to fill out all our new patient paper work and most importantly provide us your insurance information at least two business days prior to your appointment so we can verify any benefits you may have and expedite your time here. You can email all documents to broomfieldfamilydentistry@gmail.com.

As we do reserve an hour and half exclusively for your visit, we ask for a Credit card to be on file to reserve your appointment time. To avoid a $150 reservation fee, we kindly ask you give us a 3 business day notice should an unexpected event come up to reschedule your reservation.

Welcome to our family and we look forward to meeting you soon!

Credit Card #: ______________________________

Name on Credit Card: _________________________

CVC #: __________________

Sincerely,

Bromfield Family Dentistry

Dr. Samuel J. Sweeny DMD, FAGD

Cancellation Policy

At Broomfield Family Dentistry we understand that unplanned events occur and you may need to reschedule an appointment. Should that happen, we respectfully ask that you let us know at least **3 Business Days** in advance **(by phone, not text message)**. Our Doctors and Hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen for their needs.

Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no-show or appointments not cancelled within **3 Business Days**. **There will be a fee of $75.00 assessed for Hygiene appointments and $250 for Doctor appointments in the event you don't provide us with such notice.** This policy will enable us to open otherwise unused appointments to better serve the needs of all our patients. Thank you for being a valued patient and for your understanding.

Kind Regards,

Your team at Broomfield Family Dentistry

Signature:________________

Date: ______________________