# PIEDMONT FAMILY DENTISTRY
# DENTAL HISTORY QUESTIONNAIRE

Please complete this form in its entirety. Check if you have, or have had, any of the following:

| **Name** *(Last, First, M.I.):* ☐ M ☐ F | **DOB:** |
|---|---|

PLEASE ANSWER THE QUESTIONS BELOW.

| | | | |
|---|---|---|---|
| **Visit History** | **How often do you visit the Dentist?**<br>☐ Unknown ☐Never/First visit ☐1-2 per year ☐ More than twice a year ☐ Irregular ☐ Emergencies | | |
| | Are you having any discomfort at this time? ☐Yes ☐ No | | |
| | Do you need treatment every time you visit the Dentist? ☐Yes! ☐Sometimes, but not always ☐Nope, my teeth are great! | | |
| | When is the last time you had a dental cleaning? ☐6 months ago ☐1-2 years ago ☐Over 2 years ago ☐Never | | |
| **Sensitivity** | Are your teeth sensitive to: | | |
| | Sweets? | ☐Yes | ☐ No |
| | Hot? | ☐ Yes | ☐ No |
| | Cold? | ☐ Yes | ☐ No |
| | Pressure? | ☐ Yes | ☐ No |
| **Dry Mouth** | **Does your mouth feel dry?** | ☐ Yes | ☐ No |
| | Do you feel thirsty all the time? | ☐ Yes | ☐ No |
| **Gums** | Do your gums bleed when you brush? | ☐ Yes | ☐ No |
| | Do they bleed when you floss? | ☐ Yes | ☐ No |
| | Do your teeth wiggle- even slightly? | ☐ Yes | ☐ No |
| | **Have you ever had gum surgery?** | ☐ Yes | ☐ No |
| | Have you ever had, or have you ever been recommended a "deep cleaning"? | ☐ Yes | ☐ No |
| **Grinding/Jaws** | Do you have pain in your jaw joints (TMJ)? | ☐ Yes | ☐ No |
| | Does your jaw joint pop or click? | ☐ Yes | ☐ No |
| | Do you have difficulty chewing? | ☐ Yes | ☐ No |
| | **Do you clench your teeth?** | ☐ Yes | ☐ No |
| | **Do you grind your teeth?** If yes, do you wear a nightguard?_____ | ☐ Yes | ☐ No |
| **Diet** | Do you tend to sip on soft drinks for periods of time? | ☐ Yes | ☐ No |
| | Do you tend to suck on hard candy or cough drops throughout the day? | ☐ Yes | ☐ No |
| | **How many soft drinks (diet or regular), or sweet drinks (sweet tea, juice, sports drinks) do you drink in a day?**<br>☐ 5 or more<br>☐ 4 or less | | |
| **Habits** | **Smoking and Tobacco Habits** | | |

| **Cigarette History** | **Cigar/Pipe Use** | **Smokeless Tobacco Use** |
|---|---|---|
| ☐Never Used<br>☐Former Smoker-<br>☐Less than 10 per day<br>☐More than 10 per day<br>Age began smoking cigarettes_____<br>Year Quit_____ | ☐ Never used<br>☐ Former smoker<br>☐ Less than 1 per day<br>☐ 1-2 per day<br>☐ More than 2 per day<br>Age began smoking cigar/pipe_____<br>Year Quit_____ | ☐ Never used<br>☐ Former user<br>☐ Occasional user<br>☐ Daily use<br>Age began using tobacco_____<br>Year Quit_____ |

| | | | |
|---|---|---|---|
| | **Alcohol Consumption**<br><br>☐ Never had more than 12 drinks in any year of my life<br>☐ I've had more than 12 drinks in one year, but not in the past year.<br>☐ I've had more than 12 drinks in the past year, and less than 3 drinks a week<br>☐ I've had 3 to 14 drinks per week on average in the past year<br>☐ I have 2-3 drinks per day for the past year<br>☐ I have more than 3 drinks per day in the past year. | | |
| Other | **Do you have a pierced tongue or oral habit (eating ice, playing musical instrument with mouthpiece, opening bottles) that places excessive stress on your teeth?** | ☐ Yes | ☐ No |

| | | | |
|---|---|---|---|
| **Cosmetics** | Are you satisfied with the color of your teeth? | ☐ Yes | ☐ No |
| | Are you satisfied with the alignment of your teeth (how straight they are?) | ☐ Yes | ☐ No |
| | Are you satisfied with the spacing of your teeth? | ☐ Yes | ☐ No |
| | Are you interested in whitening treatments? | ☐ Yes | ☐ No |
| **Sores** | Do you have or have you ever had any swelling in your mouth or gums? | ☐ Yes | ☐ No |
| | Do you suffer with fever blisters? If so, how long do they last? _____ | ☐ Yes | ☐ No |
| | Do you suffer from ulcers? If so, how long do they last? _____ | ☐ Yes | ☐ No |
| | Does your tongue itch or burn? | ☐ Yes | ☐ No |
| | Do you bite your cheek? | ☐ Yes | ☐ No |

## ORAL HYGEINE

| | | |
|---|---|---|
| How many times a day do you brush your teeth_____ How many times a day do you floss? _____ | | |
| How often do you change your toothbrush? _____ | | |
| What is the texture of your toothbrush (select one)? ☐Soft ☐Medium ☐ Hard | | |
| What type of toothbrush do you use (select one)? ☐ Manual ☐Electric | | |
| Do you brush your tongue? | ☐ Yes | ☐ No |
| Do you chew gum? If yes, write the brand that you chew most often?_____ | ☐ Yes | ☐ No |
| **Do you use mouthwash? If yes, which brand?**_____ | ☐ Yes | ☐ No |
| **Who supplies your household drinking water (select one**)? ☐Municipality (city, county) ☐ We use well-water | | |
| **If you use well-water, do you add fluoride?** | ☐ Yes | ☐ No |
| **What brand of toothpaste do you use?** | ☐ Yes | ☐ No |
| Do you suffer from persistent bad breath (halitosis)? | ☐ Yes | ☐ No |

## OTHER QUESTIONS

| | |
|---|---|
| ☐ | Radiation therapy to the head or neck |
| ☐ | Blood Thinners |
| ☐ | GERD (acid reflux) |
| ☐ | Injury or trauma to the mouth, face or jaws |
| ☐ | Boniva or treatment for osteoporosis? |
| ☐ | Do you take vitamins? |
| ☐ | Have you had a major change in heath (heart attack, stroke, etc) during the past 12 months? |

**Are you a Diabetic?**

☐ Unknown
☐ Not Diabetic
☐ Good diabetic control
☐ Fair Diabetic Control
☐ Poor Diabetic Control

**Cancer History**

| **Have you ever had:** | **Has your parent or sibling ever had?** |
|---|---|
| ☐ Breast | ☐ Breast |
| ☐ Colon or rectum | ☐ Colon or rectum |
| ☐ Lung and Bronchus | ☐ Lung and Bronchus |
| ☐ Oral cavity | ☐ Oral cavity |
| ☐ Prostate | ☐ Prostate |
| ☐ Skin | ☐ Skin |
| ☐ Urinary bladder | ☐ Urinary bladder |
| ☐ Uterine | ☐ Uterine |
| ☐ Other | ☐ Other |
| ☐ None | ☐ None |

# MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will recieve. Thank you for answering the following questions.

Are you under a physicians care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women, Are you

☐ Pregnant/Trying to get pregnant? ☐ Nursing?

☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

| | | | | |
|---|---|---|---|---|
| ☐ AIDS/HIV Positive | ☐ Chest Pains | ☐ Frequent Headaches | ☐ Irregulat Heartbeat | ☐ Scarlet Fever |
| ☐ Alzheimer's Disease | ☐ Cold Sores/Fever Blisters | ☐ Genital Herpes | ☐ Kidney Problems | ☐ Shingles |
| ☐ Anaphylaxis | ☐ Congentital Heart Disorder | ☐ Glaucoma | ☐ Leukemia | ☐ Sickle Cell Disease |
| ☐ Anemia | ☐ Convulsions | ☐ Hay Fever | ☐ Liver Disease | ☐ Sinus Trouble |
| ☐ Angina | ☐ Cortisone Medicine | ☐ Heart Attack/Failure | ☐ Low Blood Pressure | ☐ Spina Bifida |
| ☐ Arthritis/Gout | ☐ Diabetes | ☐ Heart Murmur | ☐ Lung Disease | ☐ Stomach/Intestinal Disease |
| ☐ Artificial Heart Valve | ☐ Drug Addiction | ☐ Heart Pace Maker | ☐ Mitral Valve Prolapse | ☐ Stoke |
| ☐ Artificial Joint | ☐ Easily Winded | ☐ Heart Trouble/Disease | ☐ Pain in Jaw Joints | ☐ Swelling of Limbs |
| ☐ Asthma | ☐ Emphysema | ☐ Hemophilia | ☐ Parathyroid Disease | ☐ Thyroid Disease |
| ☐ Blood Disease | ☐ Epilepsy or Seizures | ☐ Hepatitis A | ☐ Psychiatric Care | ☐ Tonsillitis |
| ☐ Blood Transfusion | ☐ Excessive Bleeding | ☐ Hepatitis B or C | ☐ Radiation Treatments | ☐ Tuberculosis |
| ☐ Breathing Problem | ☐ Excessive Thirst | ☐ Herpes | ☐ Recent Weight Loss | ☐ Tumors or Growths |
| ☐ Bruise Easily | ☐ Fainting Spells/Dizziness | ☐ High Blood Pressure | ☐ Renal Dialysis | ☐ Ulcers |
| ☐ Cancer | ☐ Frequent Cough | ☐ Hives or Rash | ☐ Rheumatic Fever | ☐ Venereal Disease |
| ☐ Chemotherapy | ☐ Frequent Diarrhea | ☐ Hypoglycemia | ☐ Rheumatism | ☐ Yellow Jaundice |

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN Please Print and Sign DATE Print Out and Date

# PATIENT REGISTRATION

ID: _____ Chard ID: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

**Responsible Party (if someone other than the patient)**

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: Please Print and Sign

Birth Date: Print Out and Date Soc. Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

**Patient Information**

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

Email: _____ ☐ I would like to recieve correspondences via email.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: _____ Pref Dentist: _____

Employer ID: _____ Pref Pharmacy: _____

Carrier ID: _____ Pref Hyg.: _____

Section 3

Additional Comments

**Primary Insurance Information**

Name of Insured: _____ Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Ins. Company: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

**How did you hear about Piedmont Family Dentistry?**

☐ Friend or Family Member (Please include the person's name) _____

☐ Phone Book (Please Specify) _____

☐ Insurance Booklet (Please Specify) _____

☐ Newspaper ad or article (Please Specify) _____

☐ Radio Ad (Please Specify) _____

☐ Piedmont Family Dentistry website

☐ Saw the sign and walked on in!

☐ I'm not sure, but I'm glad I'm here!

☐ Other (Please Specify) _____

PIEDMONT FAMILY DENTISTRY

PRESERVING. RESTORING. ENHANCING. SMILES.

# APPOINTMENT & FINANCIAL POLICIES

Piedmont Family Dentistry strives to provide our patients with the best dental care at reasonable rates. In an effort to do so, we will continuously manage our all available resources by instituting these Appointment and Financial Polices with our patients.

**Please review our Appointment and Financial Policies carefully** and fill out the appropriate information. A copy of this information is available online at www.piedmontdental.com; or upon request from the Front Office Coordinator.

---

## APPOINTMENT POLICY

**DEFINITION OF "NO-SHOW":** A "No-show" is a patient who:

- **Does not show up** for their scheduled appointment.
- **Cancels** or **reschedules** their appointment with **less than 24 hours notice.**

### A. OUR RESPONSIBILITY TO OUR PATIENTS:

- For your convenience, we will call with an appointment reminder ***at least* 2 days prior to your scheduled appointment.**
- We will **not** charge patients a missed appointment fee.
- The best way to contact you to is (*check one):* Home ☐ Work☐ Mobile☐ Email☐

### B. OUR PATIENTS' RESPONSIBILITY:

- We require **a minimum of 24 hours notice** to reschedule an appointment.
- We allow for **one (1) No-Show** within a **12 month period**.
- Upon the second No-Show within a 12 month period, **we will discontinue seeing the patient**. We will forward their records to the dental provider of their choice, upon request.

*I certify by my signature that I have read the above Appointment Policy and will comply.*

_____ ___/____/_____

Signature Date

## FINANCIAL POLICY

**GENERAL**

- Our patients should provide current insurance information at each office visit, or upon request
- Piedmont Family Dentistry is a fee-for-service facility. As such, payment is expected when services are rendered.
- Unpaid balances will be paid **within 45 days** of office visit.
- All balances **older than 90 days** will be **turned over to a collection agency** for payment and/or legal action.

**PAYMENT OPTIONS**

- For your convenience we accept **Visa**, **MasterCard**, **Discover** and **American Express**. We also accept payment from **Employee Flex Accounts**.
- We have teamed up with **Capital One's HealthCare Finance** plan to offer an affordable way to achieve their optimal treatment goals. For more information, ask to speak with our Financial Coordinator; visit www.piedmontdental.com and click on "Payment Options".
- There will be a **$25.00 return fee charge for all returned checks**. After that, we will no longer be able to accept checks as an acceptable form of payment.
- We offer a **5% discount for payment in full on treatment plans totaling $500.00**. This discount does not apply to insurance co-payments or office visit fees.

**INSURANCE**

- For your convenience **we accept various forms of dental insurance** and we will, at no extra charge, file your claim on your behalf.
- All treatment payment plans involving your insurance company is **only an estimate and not a guarantee of coverage**.
- Any charges not covered under an insurance plan will be patient's responsibility. We will assist where possible; however **we will not pursue collection from your insurance company, or any third party, on your behalf**.
- We **do not accept secondary insurance coverage**.
- **Emergency patients** who are not of record **shall pay for services when they are rendered**. We will assist in providing the necessary information you may need to file a claim with your insurance company.

BUTOGWA M. TIAGHA, DMD, PLLC

1736 DICKERSON BLVD, SUITE C . MONROE, NC . 28110

(704) 225-8555 . (704) 225-8556 (fax)

WWW.PIEDMONTDENTAL.COM

**PAYMENT PLANS**

o We do offer reasonable payment plans. For these options, **payment is due as defined in the payment plan** and payment in full will coincide with completion of treatment.

*I certify by my signature that I have read the above Financial Agreement and will comply.*

_____ ___/____/_____

Signature Date

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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

_____
Please Print 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)

_____

_____

_____

# 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 _____, 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 practices 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 qualifications 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 based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your 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 health 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 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 $0._____ for each page, $_____ 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 your 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 contact 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: Butogwa M. Tiagha, DMD

Telephone: (704) 225-8555 Fax: (704) 225-8556

E-mail: admin@piedmontdental.com

Address: 1736 Dickerson Blvd. Suite C&D, Monroe, NC 28110

---