TRANQUIL FAMILY DENTISTRY

PLEASE PRINT

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S LEGAL NAME LAST FIRST MI	DATE OF BIRTH	SEX	SSN(US) / SIN(CAN)

PREFER TO BE CALLED	HOME PHONE #	CELL PHONE #

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

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

WORK ADDRESS STREET APT# CITY STATE ZIP/POSTAL CODE	WORK PHONE #

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

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

TRANQUIL FAMILY DENTISTRY

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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	SSN(US) / SIN(CAN)
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	SSN(US) / SIN(CA)
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 (1) any available insurance benefits to be paid directly to my dentist, (2) the release of my dental health care information for any of my dental health care insurance claim, (3) the use of my dental records by my dentist in any professional manner that he/she determines, (4) the making of videotapes, photographs, and x-rays of my dental care treatment (collectively "My Images"), and (5) my dentist's use of My Images in scientific papers, demonstrations and/or presentations without compensation to me. I agree that to the extent the cost of the dental care provided by my dentist is not covered by insurance, I am obligated to pay him/her such uninsured cost (the "Uninsured Costs") in accordance with his/her payment terms and policies. Finally, I certify that I have read or had read to me the contents of this form and understand the risks and limitations involved with the dental treatment that I am to receive.

SIGNATURE - PATIENT / GUARDIAN	DATE
WITNESS SIGNATURE	DATE

If the above named Patient is a minor or unable to pay the his/her Uninsured Costs, the undersigned agrees to guaranty the payment of such Uninsured Costs to the Patient's dentist in accordance with his/her payment terms and policies.

SIGNATURE - GUARANTOR OF PATIENT	DATE

TRANQUIL FAMILY DENTISTRY
2820 Selwyn Ave., Suite 280
Charlotte, NC 28209

NOTICE OF PRIVACY PRACTICES

The dental practice of **Tranquil Family Dentistry** has a Legal Duty to keep your personal health information private and to:

1. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical and dental information.
2. Follow the terms of the current notice.
3. Notify you in a timely manner of an accidental disclosure of your private health information.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices: When we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

USE AND DISCLOSURE OF YOUR PRIVATE HEALTH INFORMATION

The following describes different ways that we use and disclose your private health information. Not every use or disclosure is listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical or dental information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

1. We may use your PHI to provide you with dental treatment or services. We may disclose medical information about you to healthcare providers who may be involved in your treatment both directly and indirectly.

2. We may use and disclose your PHI for payment purposes. A bill may be sent to you, a third-party payer or to a collection agency. The information on or accompanying the bill may include your treatment information.

3. We will not sell or use your personal health information for marketing or fundraising purposes without first obtaining your signed authorization.

4. We are required to inform you if there are any financial conflicts of interest with us and the products or services utilized by us.

5. If you pay for your dental treatment and request that we not disclose the procedure to your insurance company we must comply with your request as long as you pay in full for the procedure in a timely manner.

6. You have the right to request a copy of your health records and to request the type of format you want (paper or electronic). If you request, in writing, that a copy of your records be sent to a specific third party, we are required to send them as directed and in a timely manner.

PATIENT ACKNOWLEDGEMENT

I understand that I may request in writing that you restrict how my private health information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT/GUARDIAN NAME: (PRINT)_____

RELATIONSHIP TO PATIENT:_____

SIGNATURE: _____ DATE: _____

Financial and Cancellation Policy
Privacy Policy

A. _____ **I would like to have Tranquil Family Dentistry file my insurance on my behalf.** I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover at time of service. I hereby authorize payment directly to Tranquil Family Dentistry otherwise payable to me. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance.

I will be responsible for any remaining balance beyond of the reimbursement amount provided by my insurance coverage. I understand that I will receive a statement if there is a balance left from any treatment, and that I have the opportunity to pay the balance at that time.

Signature _____ Date _____

Print Name _____

B. _____ **I agree to pay the full fee for all services received on the day of my visit.** I understand that Tranquil Family Dentistry will still file my insurance for me, and if available, on my behalf. **I will then be directly reimbursed by my insurance company** within a few weeks following the filed claim. I further understand that I will be responsible to pay in full for any routine visits (including exams, x-rays, and routine cleanings) even if they will be reimbursed to me in full.

Signature_____ Date_____

Print Name_____

C. _____ Our office understands that sometimes unforeseen circumstances may prevent you from keeping your scheduled appointment. However, **we do request that you notify us at least one full business day prior to your scheduled appointment time, if you are unable to keep your appointment.** Our office is open Monday through Thursday. *We are reserving this time for you, so please have the courtesy to notify us when these changes occur in your schedule.*

If you do not show for your scheduled appointment or if we do not receive notice within one full business day, we reserve the right to charge a broken appointment fee of $50. For any appointment for treatment procedures with the dentist, the fee will be determined according to the treatment scheduled For repeated missed/broken appointments, we reserve the right to require a non-refundable deposit for any subsequent visits. This deposit must be paid prior to any future visits, until further notice, including restorative and cleaning appointments. These deposits can be used to cover any portion of my responsibility for payment outside for the insurance company's portion.

Signature_____ Date_____

D. **Privacy Policy: I have received the Notice of Privacy Practices provided by this office.**

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 or bad reaction to any of the following:	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine _____		
☐ penicillin _____		
☐ erythromycin _____		
☐ tetracycline _____		
☐ sulfa _____		
☐ local anesthetic _____		
☐ fluoride _____		
☐ chlorhexidine (CHX) _____		
☐ Iodine _____		
☐ metals (nickel, gold, silver, _____)		
☐ latex _____		
☐ nuts _____		
☐ fruit _____		
☐ milk _____		
☐ red dye _____		
☐ 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. orthopedic or soft tissue implant (e.g., joint replacement, breast implant)	☐	☐
8. heart murmur, 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 (or INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
15. breathing problems (e.g., asthma, stuffy nose, sinus congestion) _____	☐	☐
16. sleep problems (e.g., sleep apnea, snoring, insomnia, restless sleep, bedwetting)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease or jaundice _____	☐	☐
19. vertigo (e.g., "the room is spinning") _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency or imbalance (e.g., polycystic ovarian syndrome) _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g., gastric reflux, bulimia, anorexia, celiac disease, Crohn's disease, or any inflammatory bowel disease) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g., bisphosphonates) _____	☐	☐
27. arthritis or gout _____	☐	☐
28. autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma) _____	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (e.g., Alzheimer's disease, dementia, prion disease)	☐	☐
34. viral infections (e.g., cold sores) bacterial infections (e.g., Lyme disease)	☐	☐
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. difficulties with stress management _____	☐	☐
44. psychiatric treatment, antidepressants, mood stabilizing medications	☐	☐
45. concentration problems or ADD/ADHD _____	☐	☐
46. alcohol/recreational 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 (e.g., fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements, vitamins, and/or probiotics _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches or chronic pain _____	☐	☐
53. a smoker, smoked previously or other (e.g., smokeless tobacco, vaping, e-cigarettes, and cannabis) _____	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

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, vitamins, and/or probiotics 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 _____

ASA _____ **(1-6)** ☐ ☐ ☐

DENTAL HISTORY

Patient 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, and at what age?	☐	☐
6. Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma?	☐	☐
GUM AND BONE		
7. Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing?	☐	☐
8. Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth?	☐	☐
9. Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing?	☐	☐
13. Have you experienced a burning, painful sensation, or metallic taste 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, not enough, or do you have difficulty swallowing or chewing 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 filling?	☐	☐
20. Do you frequently get food caught between any teeth?	☐	☐
BITE AND JAW JOINT		
21. Does your jaw joint ever have pain, sounds (popping, cracking), or experience limited opening or locking?	☐	☐
22. Do you feel like you need to pull your lower jaw back, or feel that it is being pushed back when you try to bite your back teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, raw carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
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, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better?	☐	☐
28. Do you place your tongue between your teeth or close 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 or grind your teeth together in the daytime / nighttime or ever make them sore?	☐	☐
31. Do you have any problems with sleep (i.e., restlessness or teeth grinding), 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 mouth (smile, lips, teeth, gums) that you would like to change (color, spaces, size, shape, display)?	☐	☐
34. Have you ever bleached (whitened) 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 _____

Doctor's Signature _____ Date _____

Informed Consent for Treatment

PATIENT NAME:_____ PIN: _____

I hereby authorize my dentist, Drs N. Acampado/G. Savage and whomever he/she may designate as his/her assistants and/or hygienists, to perform upon me those dental procedures which we have discussed, and I have accepted in the treatment plan. If any unforeseen condition arises in the course of these designated procedures calling, in their judgement, for procedures in addition to or different from those now contemplated, I further request and authorize whatever he/she deems advisable.

I consent to the treatment plan I have accepted after having been advised of alternate plans of treatment available.

I am informed and fully understand that there are certain risks in any dental treatment. These risks include but are not limited to: post-treatment pressure and temperature sensitivity, pain or throbbing, pulpal inflammation, fracturing of new restorations due to early biting pressures, tenderness of abutment teeth, tenderness of tissues under removable dentures, post-operative pain and throbbing, swelling and reinfection, fracturing of files or the crown portion of the tooth during and following root canal therapy, sensitivity of the teeth and gums during and following dental cleanings.

The most common of these complications in oral surgery include post-operative bleeding, swelling or bruising, discomfort, stiff jaws, and loss or loosening of dental restorations. Other less common complications include, but are not limited to: infection, loss or injury to adjacent teeth and soft tissues, jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, nerve disturbances (e.g. numbness in mouth and lip tissues), and small root fragments remaining in the jaw which might require extensive surgery for removal. These complications may be temporary or permanent.

I further consent to the administration of any drugs that may be deemed necessary in my case, including, but not limited to: local anesthetics, antibiotics, and analgesics. I understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes, but is not limited to, the following complications: adverse drug response (e.g. allergic reactions), cardiac arrest, thrombophlebitis, (e.g. irritation and swelling of a vein), aspiration, pain, discoloration, and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

A more complete explanation of all complications is available to me upon my request from the Doctor.

I am aware that, in spite of the possible complications and risks, my treatment is necessary and desired by me. I realize that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedures.

DATE	PATIENT/PARENT/GUARDIAN SIGNATURE	DOCTOR/STAFF
__/__/__	_____	_____
__/__/__	_____	_____
__/__/__	_____	_____
__/__/__	_____	_____
__/__/__	_____	_____
__/__/__	_____	_____
__/__/__	_____	_____
__/__/__	_____	_____

Tranquil
family dentistry

Authorization For Release of Dental Record

NAME OF PATIENT_____ DOB_____

ADDRESS OF PATIENT_____

_____

_____

I HEREBY AUTHORIZE _____ TO RELEASE MY MEDICAL AND DENTAL INFORMATION TO:

Tranquil Family Dentistry
2820 Selwyn Ave Suite #280
Charlotte, NC 28209
980-219-7078
tranquilfamilydentistry@gmail.com

The Information To Be Disclosed Is:

_____ Medical/dental History

_____ Treatment/progress Notes

_____ Dental X-rays

_____ Other

_____

Signature Of Patient_____ Date_____

{Parent or Guardian if patient is a minor}