MYRON L. GOTTFRIED, DDS, PLLC
HALEY GOTTFRIED MANN, DDS
1415 PATTON AVE • ASHEVILLE, NC 28806
Phone (828) 254-9692 • Fax (828) 259-9189
www.westashevilledentist.com

PLEASE PRINT

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S LEGAL NAME LAST FIRST MI	DATE OF BIRTH	SEX	SSN

PREFER TO BE CALLED	HOME PHONE NUMBER	CELL PHONE NUMBER

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

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

WORK ADDRESS STREET APT# CITY STATE/ZIP	WORK PHONE NUMBER

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

SPOUSE'S WORK ADDRESS STREET APT# CITY STATE/ZIP	WORK PHONE NUMBER

WORK ADDRESS STREET APT# CITY STATE/ZIP	WORK PHONE NUMBER

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 NUMBER	WORK PHONE NUMBER	CELL PHONE NUMBER

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

GROUP/PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS

SECONDARY COVERAGE ☐ YES ☐ NO	PATIENT'S/GUARDIAN'S EMPLOYER	OCCUPATION

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S BIRTHDAY	SUBSCRIBER'S SSN

GROUP/PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS

RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTHCARE WITH:

	YES	NO
Health Care Providers	☐	☐
Insurance Companies	☐	☐

OTHERS (PLEASE PRINT)

1.

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 claims, (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

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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		
☐ sulfa		
☐ 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. orthopedic implant (joint replacement)	☐	☐
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, shortness of breath, sarcoidosis	☐	☐
14. tuberculosis, measles, chicken pox		
15. asthma	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, 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. celiac disease, gastric reflux)	☐	☐
26. osteoporosis/osteopenia (i.e. taking bisphosphonates)	☐	☐
27. arthritis	☐	☐
28. autoimmune disease (i.e.rheumatoid arthritis, lupus, scleroderma)	☐	☐
29. glaucoma	☐	☐
30. contact lenses	☐	☐
31. head or neck injuries	☐	☐
32. epilepsy, convulsions (seizures)	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease)	☐	☐
34. viral infections and cold sores	☐	☐
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. emotional difficulties	☐	☐
44. psychiatric treatment	☐	☐
45. antidepressant medication	☐	☐
46. alcohol / recreational drug use	☐	☐
47. prostate disorders	☐	☐
ARE YOU:		
48. presently being treated for any other illness	☐	☐
49. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)	☐	☐
50. taking medication for weight management	☐	☐
51. taking dietary supplements	☐	☐
52. often exhausted or fatigued	☐	☐
53. experiencing frequent headaches	☐	☐
54. a smoker, smoked previously or use smokeless tobacco	☐	☐
55. considered a touchy / sensitive person	☐	☐
56. often unhappy or depressed	☐	☐
57. taking birth control pills	☐	☐
58. currently pregnant	☐	☐

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, and/or vitamins 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 _____

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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 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?_____

	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?	☐	☐
6. Have you had any teeth removed or missing teeth that never developed?	☐	☐
GUM AND BONE		
7. Do your gums bleed or are they painful when brushing or flossing?	☐	☐
8. Have you ever been treated for gum disease or been told that you have bone loss around your teeth?	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐
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 or do you have difficulty swallowing 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, or sweets?	☐	☐
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. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26. Are your teeth developing spaces or becoming more loose?	☐	☐
27. Do you need to bite, squeeze, or shift your jaw to make your teeth fit together?	☐	☐
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 your teeth in the daytime or make them sore?	☐	☐
31. Do you have any problems with sleep (i.e. restlessness), 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 teeth that you would like to change?	☐	☐
34. Have you ever whitened (bleached) 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 _____

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TREATMENT CONSENT FORM

I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. I also understand and consent to the following:

1. During the course of treatment, I could possibly undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance preestimate is given or a procedure has been preapproved, I am responsible for any costs that my insurance does not cover.

5. My treatment plan may change at any time due to unforeseen circumstances and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

Patient/ Guardian Name: _____ Date: _____

Witness: _____ Date: _____

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PAYMENT POLICY AGREEMENT

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we ask that you read and sign prior to any treatment. Interest at a rate of 1 ½% per month (18% per annum) is charged on balances over 30 days. We accept Cash, Checks, Visa, MasterCard, Discover & American Express Cards.

PAYMENT PLAN OPTIONS ARE AVAILABLE THROUGH OUR FINANCIAL COORDINATOR.

For those patients who DO NOT HAVE DENTAL INSURANCE, payment in full is expected for services rendered on the day of service.

INSURANCE

If the patient or responsible party has an Insurance plan, the office will produce and send claims to the insurance carrier the same day of service, provided evidence of benefits (Insurance Card/Completed and Signed Form) is presented to the office. **ANY ESTIMATED PORTION OF SERVICES NOT COVERED BY INSURANCE IS DUE ON THE DAY SERVICES ARE RENDERED.** If you need financial assistance, please speak with our financial coordinator *PRIOR* to treatment. Your Insurance Policy is a contract between you and your insurance company. We file your insurance and accept assignment of benefits as a courtesy to you, our valued patient. If your insurance company has not paid for your claim within 60 days, you are responsible for payment of the balance at that time. We will be happy to provide necessary documentation to your insurance company so that you may call them to discuss the non-payment of your claim, but we require payment from you for the account balance.

Our Practice is committed to providing the BEST TREATMENT for our patients, and our fees are reasonable for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of "Usual and Customary" rates or for alternate treatment substitute determination. "Usual and Customary" fees vary widely between different Insurance Plans.

MISSED APPOINTMENTS

In order to ensure we have appointments available for our patients we must have 24 hours notice if you must cancel a scheduled appointment. If you find you will need financial arrangements call our financial coordinator at least 48 hours prior to your appointment. *Repeated missed appointments without notice will result in dismissal from our practice*. Please help us serve you better by keeping scheduled appointments.

Patient Signature
or Responsible Party_____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____have received/been offered a copy of this office's Notice of Privacy Practices.

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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other_____

_____

_____

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AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient _____ Date of Birth _____

The office of Dr. Gottfried and Dr. Mann is authorized to release protected health information about the above named patient to the entities named below.

Entity to Receive Information Check each person/entity that may receive information.	**Description of Information to be Released** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other: _____
☐ Spouse (provide name)	☐ Financial ☐ Medical as follows:_____
☐ Parent (provide name)	☐ Financial ☐ Medical as follows:_____
☐ Other (provide name)	☐ Financial ☐ Medical as follows:_____

PATIENT INFORMATION:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.

I understand that the information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by patient.

Patient Signature
or Personal Representative _____ Date: _____