

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	
<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> 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		

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
	<input type="checkbox"/> YES <input type="checkbox"/> NO		
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT	SUBSCRIBER'S BIRTHDAY	SUBSCRIBER'S SSN / ID #
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS	
SECONDARY COVERAGE	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
	<input type="checkbox"/> YES <input type="checkbox"/> NO		
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> 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

DENTAL HISTORY

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) [____] _____ YES NO
2. Have you had an unfavorable dental experience? _____ YES NO
3. Have you ever had complications from past dental treatment? _____ YES NO
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ YES NO
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ YES NO
6. Have you had any teeth removed? _____ YES NO

SMILE CHARACTERISTICS



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

BITE AND JAW JOINT



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

TOOTH STRUCTURE



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

GUM AND BONE



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

Patient's Signature _____ Date _____

Doctor's 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 | | YES | NO |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. hospitalization for illness or injury _____ | <input type="checkbox"/> | <input type="checkbox"/> | 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. an allergic reaction to _____ | | | 27. arthritis _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine | | | 28. glaucoma _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> penicillin | | | 29. contact lenses _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> erythromycin | | | 30. head or neck injuries _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> tetracycline | | | 31. epilepsy, convulsions (seizures) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> sulfa | | | 32. neurologic problems (attention deficit disorder) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> local anesthetic | | | 33. viral infections and cold sores _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> fluoride | | | 34. any lumps or swelling in the mouth _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> metals (nickel, gold, silver, _____) | | | 35. hives, skin rash, hay fever _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> latex | | | 36. venereal disease _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> other _____ | | | 37. hepatitis (type _____) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. heart problems, or cardiac stent within the last six months _____ | <input type="checkbox"/> | <input type="checkbox"/> | 38. HIV / AIDS _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. history of infective endocarditis _____ | <input type="checkbox"/> | <input type="checkbox"/> | 39. tumor, abnormal growth _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. artificial heart valve, repaired heart defect (PFO) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 40. radiation therapy _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. pacemaker or implantable defibrillator _____ | <input type="checkbox"/> | <input type="checkbox"/> | 41. chemotherapy _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. artificial prosthesis (heart valve or joints) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 42. emotional problems _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. rheumatic or scarlet fever _____ | <input type="checkbox"/> | <input type="checkbox"/> | 43. psychiatric treatment _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. high or low blood pressure _____ | <input type="checkbox"/> | <input type="checkbox"/> | 44. antidepressant medication _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. a stroke (taking blood thinners) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 45. alcohol / street drug use _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. anemia or other blood disorder _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 12. prolonged bleeding due to a slight cut (INR > 3.5) _____ | <input type="checkbox"/> | <input type="checkbox"/> | ARE YOU: | | |
| 13. emphysema, sarcoidosis _____ | <input type="checkbox"/> | <input type="checkbox"/> | 46. presently being treated for any other illness _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. tuberculosis _____ | <input type="checkbox"/> | <input type="checkbox"/> | 47. aware of a change in your health (i.e. fever, new cough) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. asthma _____ | <input type="checkbox"/> | <input type="checkbox"/> | 48. taking medication for weight management (i.e. fen-phen) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. breathing or sleep problems (i.e. snoring, sinus) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 49. taking dietary supplements _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. kidney disease _____ | <input type="checkbox"/> | <input type="checkbox"/> | 50. often exhausted or fatigued _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. liver disease _____ | <input type="checkbox"/> | <input type="checkbox"/> | 51. experiencing frequent headaches _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. jaundice _____ | <input type="checkbox"/> | <input type="checkbox"/> | 52. a smoker, smoked previously or use smokeless tobacco _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. thyroid, parathyroid disease, or calcium deficiency _____ | <input type="checkbox"/> | <input type="checkbox"/> | 53. considered a touchy person _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. hormone deficiency _____ | <input type="checkbox"/> | <input type="checkbox"/> | 54. often unhappy or depressed _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. high cholesterol or taking statin drugs _____ | <input type="checkbox"/> | <input type="checkbox"/> | 55. FEMALE - taking birth control pills _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. diabetes (HbA1c = _____) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 56. FEMALE - pregnant _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. stomach or duodenal ulcer _____ | <input type="checkbox"/> | <input type="checkbox"/> | 57. MALE - prostate disorders _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. digestive disorders (i.e. gastric reflux) _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Describe any current medical treatment, impending surgery, 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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 _____



CRISAFULLI DENTAL
HIPPA: Health Insurance Portability and Accountability Act
NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you maybe 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 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 as of April 10, 2003 and will remain in effect until we replace it. We reserve the right to make the changes in our privacy practices and the new terms of our Notice at any time. This Notice affects all health information that we maintain, including health information we created or received before this Notice has been put into effect. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

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 dentist, physician or other healthcare provider providing treatment.

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. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

TO YOUR FAMILY AND FRIENDS: We will use or disclose 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 payment for your healthcare, but we can only do this if you agree to let us do this.

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 or location or in the case your 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 situation, we will disclose health information based on our professional judgment disclosing that is directly relevant to the person's involvement in your care which might include 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.

NATIONAL SECURITY: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other nation 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.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are possible victim of abuse, neglect, or domestic violence, or any other crime. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health and safety of others.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders, such as voicemail messages, postcards, letters, or computerized voicemail from our office.

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 (e.g. fax). We will use the format you request unless it is not practical to do so, for example, we cannot fax x-rays. You may obtain a form to request access by using the contact information listed at the end of this Notice. A request for records and/or x-rays will be available for mail or pick up within 15 days. If you request copies of your chart notes, a charge of \$3.00 per page, and \$25 for duplicate x-rays, if more than 6 months old will apply. If these x-rays are taken within the last 6 months, there will not be a charge. If you are having someone other than yourself pick up these records, you must inform us before they arrive. You or your representative must sign a record of release form prior to pick up.

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 fee for responding to these additional requests.

Restrictions: You have the right to ask us to place restrictions on our use or disclosure of your health information. By law we do not have to agree to these additional restrictions, but if we do, we will abide by our agreement, an exception would be 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 and allow us 15 days after your request to provide the information. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or locations, and provide satisfactory explanation of how payments will be handled under the alternative means or locations your request.

Amendment: You have the right to ask us that we amend your health information. Your request must also be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND CONCERNS: If you want more information about our privacy practices or has questions or concerns, please contact us. Complaints can also be written and mailed to us, or the US Department of Health and Human Services. Their website is www.hhs.gov/ocr/hipaa. We support your right to the privacy of your health information.

Contact Office: Dr. Wendy B. Crisafulli

Telephone: 425-483-5838

Email: drwendy.c@gentledds.com

Address: Crisafulli Dental

18920 Bothell Way NE, #200

Bothell, WA 98011

CRISAFULLI DENTAL

OFFICE POLICIES

I, _____, acknowledge receipt of Crisafulli Dentals Health Insurance Portability and Accountability Act (HIPAA).

Initial _____

I acknowledge payment is due at time of service. We accept all major credit/debit cards, FSA debit cards, personal check or cash.

Initial _____

I acknowledge Crisafulli Dental requires 48 hours notice for any dental cancellations to avoid a \$35.00 fee. Charges will be applied for broken appointments.

Initial _____

OFFICE STATEMENT

As our community service project, this office team is raising a Labrador puppy to be in the Canine Companions for Independence Program. With much TLC, this dog will go on to assist someone that is disabled. This puppy, although under our supervision, is not fully trained yet. This dog may be either in the front lobby or in the clinical area.

I acknowledge that there is a dog in this office. If I have a fear of dogs or an extreme allergy to dogs, I am to let the receptionist know so that arrangements can be made to put the puppy in Dr. Crisafulli's private office during my appointment.

Initial _____

Signature _____

Date _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice Privacy Practices, but acknowledgement could not be obtained because:

- _____ The individual refused to sign
- _____ Communication barriers prohibited obtaining the acknowledgement
- _____ An emergency situation prevented us from obtaining acknowledgement
- _____ Other (please specify) _____