

# Confidential Information Questionnaire

Patient's name \_\_\_\_\_ Date of birth \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Mailing address Apt # City State Zip

Phone \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

Social security number \_\_\_\_\_ Sex M / F Marital status M / S / D

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer address \_\_\_\_\_ Work phone \_\_\_\_\_

\*Person responsible for this account \_\_\_\_\_ Relationship \_\_\_\_\_

Spouse or parent name \_\_\_\_\_  
Last First Middle Relationship

Spouse/parent employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's address \_\_\_\_\_ Phone \_\_\_\_\_

Emergency person we can contact \_\_\_\_\_ Phone \_\_\_\_\_

Names of other family members who are patients here \_\_\_\_\_

**Whom may we thank for referring you to our office?** Please check all that apply.

Family member \_\_\_\_\_ Friend (name) \_\_\_\_\_ Radio \_\_\_\_\_ Phone book \_\_\_\_\_ Website \_\_\_\_\_

Did you choose our office because of: Our reputation \_\_\_\_\_ Our ability to care for high-anxiety patients \_\_\_\_\_  
Our location \_\_\_\_\_ Other \_\_\_\_\_

## Insurance Information

Do you have dental insurance? Yes \_\_\_\_ No \_\_\_\_ Name and address of subscriber \_\_\_\_\_

Subscriber's SS# or ID# \_\_\_\_\_ Subscriber's DOB \_\_\_\_\_

Insurance company \_\_\_\_\_ Group# \_\_\_\_\_ Phone \_\_\_\_\_

Mailing address for claims \_\_\_\_\_

Do you have secondary dental insurance? Yes \_\_\_\_ No \_\_\_\_ Name of subscriber \_\_\_\_\_

Subscriber's SS# or ID# \_\_\_\_\_ Subscriber's DOB \_\_\_\_\_

Insurance company \_\_\_\_\_ Group# \_\_\_\_\_ Phone \_\_\_\_\_

Insurance mailing address \_\_\_\_\_

## Assignment and Release

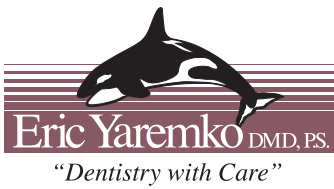
I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balance due and authorize the dentist to release any information required for this claim. I authorize that my records can be used by the doctor if he so determines.

In consideration of the service rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy. Please refer to our written Financial Policy.

I consent to the taking of photographs and X-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers and 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 \_\_\_\_\_ Date \_\_\_\_\_



## Insurance Exclusion Disclaimer

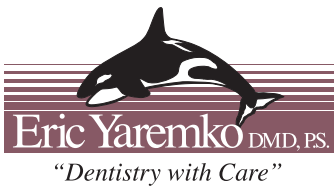
Dear Patient:

Our practice is designed to provide excellent, quality care and specific, detailed, individualized treatment. We do not provide discount care.

Be advised that although we accept assignment from almost all insurance companies, we are **not** discount providers for any (your insurance company will call this a preferred provider organization or PPO).

I acknowledge that I have been informed that Eric Yaremko DMD does **not** participate in any PPO plan.

Signature \_\_\_\_\_ Date \_\_\_\_\_



## Financial Policy

**As a patient with dental insurance, you are ultimately responsible to know and understand your dental coverage.** We will gladly submit your dental charges to your insurance company for you. If we are unable to collect from your insurance company within 90 days, the amount expected from them will become your responsibility. We make every effort to calculate the estimated copayment you will have for each procedure. This will be reviewed with you prior to treatment and due at time of service. **We can only track the amount of insurance dollars used in our office. If you are seen at any other office, you need to calculate that into any estimates we give you.**

**As a cash patient,** your estimated cost of procedures will always be reviewed by us prior to treatment, and this amount will be due at the time of treatment. To make this convenient for you, we accept cash, check, Visa, MasterCard, Discover, American Express, and debit cards with Visa or MasterCard logos.

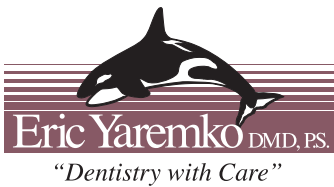
**There will be a fee of \$40 per half hour for any missed appointments or appointments canceled with less than 48 hours' notice.**

Because our office is not set up as a loan institution, we cannot carry your account. We ask that you get outside financing for any amount you cannot pay at the time of service. **Please remember that financing must be arranged prior to your treatment.**

Patients having crown or bridge work done must pay their portion at the preparation date of the procedure. If after 120 days from the preparation date the crown or bridge has not been placed due to no fault of Dr. Yaremko, you will be responsible for the entire cost.

**The treatment plan you are given prior to treatment is an estimate only and is valid for 90 days.**

Date \_\_\_\_\_ Patient Signature \_\_\_\_\_



## Acknowledgment of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Eric A. Yaremko, DMD, PS. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my statements, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my right and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Eric A. Yaremko, DMD, PS, reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

### Additional Disclosure Authorization

*In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the person(s) identified below. (I understand that the default answer is "NO." Without indicating "YES" in answer to each individual question, personal protected health information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)*

Spouse only	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any member of my immediate family: (Spouse, Children, Children's Spouses)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any member of my extended family: (Parents, Grandchildren)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name of patient (please print): \_\_\_\_\_

Patient signature: \_\_\_\_\_

Patient's personal representative (please print): \_\_\_\_\_

Personal representative's signature: \_\_\_\_\_

Representative's phone number: \_\_\_\_\_ Date: \_\_\_\_\_

### OFFICE USE ONLY BELOW THIS LINE

#### Acknowledgment Not Obtained

Provided Prior to Treatment ☐ Yes ☐ No Date Statement Provided: \_\_\_\_\_

Reason for not obtaining patient signature:

- ☐ Needed more time to review Statement
- ☐ Wanted to consult another person before signing
- ☐ Physically unable to sign
- ☐ No reason offered
- ☐ Other

## 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?** \_\_\_\_\_

### Personal History

	Yes	No
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most)? _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you had an unfavorable dental experience? _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had complications from past dental treatment? _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Did you ever have braces, orthodontic treatment, or a bite adjustment? _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any teeth removed? _____	<input type="checkbox"/>	<input type="checkbox"/>

### Gum and Bone

7. Do your gums bleed or are they painful when brushing or flossing? _____	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>
10. Is there anyone with a history of periodontal disease in your family? _____	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever experienced gum recession? _____	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you experienced a burning sensation in your mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>

### Tooth Structure

14. Have you had any cavities within the past 3 years? _____	<input type="checkbox"/>	<input type="checkbox"/>
15. Does the amount of saliva in your mouth seem too small or do you have difficulty swallowing food? _____	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you feel or notice any holes (e.g., pitting, craters) on the biting surface of your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
17. Are any teeth sensitive to hot, cold, biting, or sweets, or do you avoid brushing any part of your mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you have grooves or notches on your teeth near the gum line? _____	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	<input type="checkbox"/>	<input type="checkbox"/>
20. Do you frequently get food caught between any teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>

### Bite and Jaw Joint

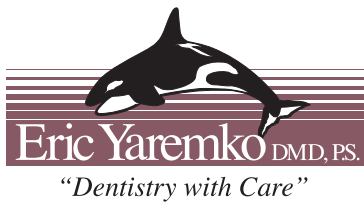
	Yes	No
21. Do you have problems with your jaw joint? (e.g., pain, sounds, limited opening, locking, popping) _____	<input type="checkbox"/>	<input type="checkbox"/>
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____	<input type="checkbox"/>	<input type="checkbox"/>
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____	<input type="checkbox"/>	<input type="checkbox"/>
24. Have your teeth changed in the last 5 years (become shorter, thinner, or worn)? _____	<input type="checkbox"/>	<input type="checkbox"/>
25. Are your teeth crowding or developing spaces? _____	<input type="checkbox"/>	<input type="checkbox"/>
26. Do you have more than one bite and squeeze to make your teeth fit together? _____	<input type="checkbox"/>	<input type="checkbox"/>
27. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	<input type="checkbox"/>	<input type="checkbox"/>
28. Do you clench your teeth in the daytime or make them sore? _____	<input type="checkbox"/>	<input type="checkbox"/>
29. Do you have any problems with sleep or wake up with an awareness of your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
30. Do you wear or have you ever worn a bite appliance? _____	<input type="checkbox"/>	<input type="checkbox"/>

### Smile Characteristics

31. Is there anything about the appearance of your teeth that you would like to change? _____	<input type="checkbox"/>	<input type="checkbox"/>
32. Have you ever whitened (bleached) your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
33. Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
34. Have you been disappointed with the appearance of previous dental work? _____	<input type="checkbox"/>	<input type="checkbox"/>

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's signature \_\_\_\_\_ Date \_\_\_\_\_



**360.734.6620**  
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EricYaremkoDMD.com

## 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, rheumatoid arthritis, lupus _____                 | <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 disorders (e.g., ADD/ADHD, prion disease) _____   | <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. STI/STD _____  | <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, immunosuppressive _____                        | <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"/> |  |                          |                          |
| 13. Emphysema, shortness of breath, sarcoidosis _____                  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 14. Tuberculosis, measles, chickenpox _____                            | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 15. Asthma _____   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 16. Breathing/sleep problems (e.g., sleep apnea, snoring, sinus) _____ | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 17. Kidney disease _____   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 18. Liver disease _____  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 19. Jaundice _____   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 20. Thyroid or parathyroid disease, or calcium deficiency _____        | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 21. Hormone deficiency _____   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 22. High cholesterol or taking statin drugs _____                      | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 23. Diabetes (HbA1c = _____) _____                                     | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 24. Stomach or duodenal ulcer _____                                    | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 25. Digestive disorders (e.g., celiac disease, gastric reflux) _____   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |

### ARE YOU:

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 46. Presently being treated for any other illness _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 47. Aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, diarrhea) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 48. Taking medication for weight management (e.g., fen-phen) _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 49. Taking dietary supplements _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 50. Often exhausted or fatigued _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 51. Experiencing frequent headaches _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 52. A smoker, smoked previously, or use smokeless tobacco _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 53. Considered a touchy person _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 54. Often unhappy or depressed _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 55. FEMALE - taking birth control pills _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 56. FEMALE - pregnant _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 57. MALE - suffering a prostate disorder _____   | <input type="checkbox"/> | <input type="checkbox"/> |

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment (e.g., Botox, collagen injections).

List all medications, supplements, and/or vitamins taken within the last two years (ask for an additional sheet if taking more than six)

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 \_\_\_\_\_