



**Confidential Information Questionnaire**

Patient's Name	Last	First	Middle	Prefer to be Called	
Patient's Address			Postal Code	Date of Birth	Sex
Marital Status <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> Under Age 18		Patient's Employer/School		Occupation	
Social Security Number		Driver's License Number		Email Address	
Home Phone		Work Phone		Cell Phone	

***Please Circle Your Preferred Way of Communication Above***

**Cancellation Policy**

Since our time with our patients is precious and lost time is irretrievable, we must charge for broken appointments when we have not been notified at least 48 hours in advance. We understand that things do arise, but please be considerate to all our patients' needs and our allotted time reservation for you.

Our desire is never to make this charge.

We are reserving this time especially for you and do not double book this time.

*Our broken appointment fee is \$150.*

**Insurance**

Your dental insurance plan represents a contract between you and the insurance company. As a courtesy, we file the necessary paperwork to the insurance company to process your dental claim. We work diligently to provide you with as much information about your insurance coverage as possible including: deductibles, annual maxims, etc. Please understand that the insurance companies will **not** provide all the information required to make coverage estimates perfectly. The information we provide is an estimate and patients are ultimately responsible for the full balance. All unpaid insurance balances beyond 60 days from the date of service will become the responsibility of the patient.

Thank you for understanding!

I have read and understand all above policies. I additionally authorize Dr. Parry to use any records (including photographs) for professional presentations and discussing dental health with others.

**Signature of patient, parent or guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# HIPAA NOTICE OF PRIVACY PRACTICES

Magnolia Shores Family Dentistry 1009 NC HWY 150W Summerfield, NC 27358

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, and future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides you care. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of our physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may take photographs of you before and/or after treatment to be posted on our office bulletin boards displayed in the office. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Disease: Health Oversight Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation. Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will be Made Only With Your Consent, Authorization, or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes: information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative notion or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to disclose any part of your protected health information for purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your case or for notification purposes as described in this Notice of Privacy Practices. Your request must state specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclose your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main office phone number.

Signature below acknowledgement that you have received this Notice of our Privacy Practices

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



## Records Release Form

To: \_\_\_\_\_

Fax: \_\_\_\_\_ Phone: \_\_\_\_\_

*I hereby authorize the release my full dental records, including but not limited to, xrays, periodontal charting, restorative charting and treatment notes.*

Name of patient(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

Please forward all information via email to:

[info@magnoliashoresfamilydental.com](mailto:info@magnoliashoresfamilydental.com)

1009 NC Highway 150 W - Summerfield, NC 27358

Phone: 336/644-2770 Fax: 336/644-2778

# 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:

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)
  - metals (nickel, gold, silver, \_\_\_\_\_)
  - latex \_\_\_\_\_
  - nuts \_\_\_\_\_
  - fruit \_\_\_\_\_
  - milk \_\_\_\_\_
  - red dye \_\_\_\_\_
  - other \_\_\_\_\_

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 (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 or antidepressant medication \_\_\_\_\_
45. concentration problems or ADD/ADHD diagnosis \_\_\_\_\_
46. alcohol/recreational drug use \_\_\_\_\_

YES NO

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. celiac disease, gastric reflux, bulimia, anorexia) \_\_\_\_\_

## 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 \_\_\_\_\_
51. often exhausted or fatigued \_\_\_\_\_
52. experiencing frequent headaches or chronic pain \_\_\_\_\_
53. a smoker, smoked previously or other (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, 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 \_\_\_\_\_

# 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:

### 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 had your bite adjusted, and at what age? _____                      | <input type="checkbox"/> |     | <input type="checkbox"/> |
| 6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? _____ | <input type="checkbox"/> |     | <input type="checkbox"/> |

### GUM AND BONE

- |   |                          | YES | NO                       |
|---|--------------------------|-----|--------------------------|
| 7. Do your gums bleed sometimes or are they ever 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, or can you see more of the roots of your teeth? _____                              | <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 or painful sensation in your mouth not related to your teeth? _____                          | <input type="checkbox"/> |     | <input type="checkbox"/> |

### TOOTH STRUCTURE

- |  |                          | YES | NO                       |
|--|--------------------------|-----|--------------------------|
| 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 little or do you have difficulty swallowing any food? _____ | <input type="checkbox"/> |     | <input type="checkbox"/> |
| 16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____           | <input type="checkbox"/> |     | <input type="checkbox"/> |
| 17. Are any teeth sensitive to hot, cold, biting, 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? (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 try to bite your back 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. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____                              | <input type="checkbox"/> |     | <input type="checkbox"/> |
| 25. Are your teeth becoming more crooked, crowded, or overlapped? _____  | <input type="checkbox"/> |     | <input type="checkbox"/> |
| 26. Are your teeth developing spaces or becoming more loose? _____   | <input type="checkbox"/> |     | <input type="checkbox"/> |
| 27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? _____ | <input type="checkbox"/> |     | <input type="checkbox"/> |
| 28. Do you place your tongue between your teeth or close your teeth against your tongue? _____   | <input type="checkbox"/> |     | <input type="checkbox"/> |
| 29. 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"/> |
| 30. Do you clench or grind your teeth together in the daytime or make them sore? _____   | <input type="checkbox"/> |     | <input type="checkbox"/> |
| 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? _____      | <input type="checkbox"/> |     | <input type="checkbox"/> |
| 32. Do you wear or have you ever worn a bite appliance? _____  | <input type="checkbox"/> |     | <input type="checkbox"/> |

### SMILE CHARACTERISTICS

- |  |                          | YES | NO                       |
|--|--------------------------|-----|--------------------------|
| 33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)? _____ | <input type="checkbox"/> |     | <input type="checkbox"/> |
| 34. Have you ever whitened (bleached) your teeth? _____  | <input type="checkbox"/> |     | <input type="checkbox"/> |
| 35. Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____  | <input type="checkbox"/> |     | <input type="checkbox"/> |
| 36. 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 \_\_\_\_\_