

# Dental Questionnaire

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. Are you having any discomfort at this time?  Yes  No
2. Have you ever had any serious trouble associated with previous dentistry  Yes  No
3. Does dental treatment make you nervous?  No  Slightly  Moderately  Extremely
4. Date of last dental visit? \_\_\_\_\_
5. Have you ever been treated for periodontal disease?  
(gum disease, pyorrhea, trench mouth)
6. How often do you brush? \_\_\_\_\_ Brush is:  Soft  Medium  Hard
7. Do you have any of the following:

- |                                |  |                              |  |
|--------------------------------|--|------------------------------|--|
| Unpleasant taste or bad breath | <input type="checkbox"/> Yes <input type="checkbox"/> No | Denture or Removable Partial | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding, sore gums            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Loose teeth                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Smoke or use Tobacco           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitive to hot             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Burning tongue/lips            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitive to cold            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Frequent blisters, lips/mouth  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitive to sweet           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Swelling/lumps, in mouth       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitive to biting          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Orthodontics (Braces)          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Food impaction               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Biting cheeks/lips             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Clenching/grinding           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Clicking/popping jaw           | <input type="checkbox"/> Yes <input type="checkbox"/> No | If so, when? _____           |  |
| Difficulty opening/closing jaw | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shifting in bite             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                |  | Change in bite               | <input type="checkbox"/> Yes <input type="checkbox"/> No |

8. Do you use the following?

- |                     |  |                                      |  |
|---------------------|--|--------------------------------------|--|
| Electric Toothbrush | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dental Floss                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fluoride rinse      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other <input type="checkbox"/> _____ |  |

These are the things that are important to me about my dental health: \_\_\_\_\_

What do you fear most about dental care? \_\_\_\_\_

Circle One:

1. My mouth is  
a) very comfortable  
b) moderately comfortable  
c) uncomfortable
2. I  
a) think the appearance of my mouth is excellent  
b) am satisfied with the appearance of my mouth  
c) am dissatisfied with the appearance of my mouth
3. I  
a) will do anything to keep my natural teeth  
b) want to keep my teeth, but have a certain budget of time and money that I am willing to spend on them.
4. I  
a) have set goals for my oral health with a previous dentist  
b) want to set goals concerning my dental health
5. I  
a) have always done the best that was recommended for my dental health  
b) have not done what dentists have recommended to me  
c) rarely go, and don't care much about having any dental work completed
6. I  
a) have put dentistry for myself and my family *high* on my priority list  
b) put dentistry for myself and my family *low* on my priority list  
c) have dentistry on my list but it's hard to find
7. I think my present state of dental health is:  
a) Excellent   
b) Good   
c) Poor

What are some questions about dentistry and oral health that you have never had adequately answered? \_\_\_\_\_

# Medical Questionnaire

Name \_\_\_\_\_

Correct answers to the following questions will allow your dentist to treat you so there WILL NOT be an emergency. However, if an emergency situation does arise this information will help insure proper treatment. As before, your answers are for our records only and will be considered confidential.

## Do you have or have you ever had:

Anemia  Yes  No  Previously  
Asthma  Yes  No  Previously  
Tuberculosis  Yes  No  Previously  
Diabetes  Yes  No  Previously  
HIV/AIDS  Yes  No  Previously  
Hepatitis Type: \_\_\_\_\_  Yes  No  Previously  
Epilepsy  Yes  No  Previously  
Psychiatric Treatment  Yes  No  Previously  
Drug/Alcohol Dependent  Yes  No  Previously  
Recreational Drug Use  Yes  No  Previously  
High Blood Pressure  Yes  No  Previously  
Abnormal Bleeding  Yes  No  Previously  
Pregnant or Nursing  Yes  No  
Joint Replacement  Yes  No

If yes, what & when \_\_\_\_\_

## Allergies

To Penicillin  Yes  No  
To Latex  Yes  No  
To Anesthetic  Yes  No  
Other \_\_\_\_\_

Abnormal Heart Condition  Yes  No  Previously  
Rheumatic Fever  Yes  No  Previously  
Mitral Valve Prolapse  Yes  No  Previously  
Heart Murmur  Yes  No  Previously  
Stroke  Yes  No

If so, when \_\_\_\_\_

Heart Attack  Yes  No

If so, when \_\_\_\_\_

Heart Surgery  Yes  No

If so, when \_\_\_\_\_

Pacemaker  Yes  No

Date Placed \_\_\_\_\_

Cancer  Yes  No  Previously

If yes, what type \_\_\_\_\_

Chemo or Radiation  Yes  No  Previously

If yes, when \_\_\_\_\_

Any Mental Limitations  Yes  No

If yes, in what way \_\_\_\_\_

Any Physical Limitations  Yes  No

If yes, in what way \_\_\_\_\_

Are you taking ANY medication? *This includes prescription, herbal & over the counter medicines?*  Yes  No

If yes, please list \_\_\_\_\_

Please note any disease, condition or problem not listed. \_\_\_\_\_

Are you being monitored by a Doctor for anything right now?  Yes  No

If yes, for what? \_\_\_\_\_

Date of last medical exam \_\_\_\_\_ Name of Physician(s) \_\_\_\_\_

Pharmacy Preference \_\_\_\_\_ Phone # \_\_\_\_\_

In case of emergency, who should be notified? Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_

To the best of my knowledge all the preceding answers are true and correct.

I will inform your office of any changes at the next appointment

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

# Patient Information

Date \_\_\_\_\_ 20 \_\_\_\_\_

Patient's Name \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
Last First MI Nickname

Address \_\_\_\_\_  
Street Apt# City State Zip

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ ext \_\_\_\_\_ Birth Date \_\_\_\_\_

If a child, give Parent or Guardian's Name \_\_\_\_\_ S.S.# \_\_\_\_\_

Were you referred to us?  Yes  No If Yes, who may we thank? \_\_\_\_\_

## Responsible Party Information

Name \_\_\_\_\_ Marital Status \_\_\_\_\_  
Last First MI

Address \_\_\_\_\_ Birth Date \_\_\_\_\_  
Street Apt# City State Zip

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ ext \_\_\_\_\_ S.S.# \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ # of Years Employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Last First MI

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ ext \_\_\_\_\_ S.S.# \_\_\_\_\_

## Dental Insurance Information

Insured's Name \_\_\_\_\_ S.S.# \_\_\_\_\_  
Last First MI

Insured's Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_ Phone \_\_\_\_\_

Dental Insurance Company Address \_\_\_\_\_  
Street City State Zip

Ins. Company Phone # \_\_\_\_\_ Group # \_\_\_\_\_ Effective date of Dental Insurance \_\_\_\_\_

Do you have dual coverage?  Yes  No \_\_\_\_\_ If Yes, complete the following:

Insured's Name \_\_\_\_\_ S.S.# \_\_\_\_\_  
Last First MI

Insured's Employer \_\_\_\_\_ Employer Address \_\_\_\_\_ Phone \_\_\_\_\_

Dental Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_

Insurance Company Address \_\_\_\_\_  
Street City State Zip

## Notice of Privacy Practices

Joel C. Scalera D.D.S. P.A.

1400 Dixon Blvd. Cocoa, FL 32922

(321) 636-8120

33 Suntree Place Suite A, Melbourne, FL 32940

(321) 259-3283

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

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **September 20, 2013**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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### **HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

**Treatment.** We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

**Payment.** We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

**Healthcare Operations.** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

**Individuals Involved in Your Care or Payment for Your Care.** We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

**Disaster Relief.** We may use or disclose your health information to assist in disaster relief efforts.

**Required by Law.** We may use or disclose your health information when we are required to do so by law.

**Public Health Activities.** We may disclose your health information for public health activities, including disclosures to:

- o Prevent or control disease, injury or disability;
- o Report child abuse or neglect;
- o Report reactions to medications or problems with products or devices;
- o Notify a person of a recall, repair, or replacement of products or devices;
- o Notify a person who may have been exposed to a disease or condition; or
- o Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

**National Security.** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

**Secretary of HHS.** We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

**Worker's Compensation.** We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

**Law Enforcement.** We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

**Health Oversight Activities.** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Judicial and Administrative Proceedings.** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either

by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

**Research.** We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

**Coroners, Medical Examiners, and Funeral Directors.** We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

**Fundraising.** We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

#### **Other Uses and Disclosures of PHI**

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

#### **Your Health Information Rights**

**Access.** You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

**Disclosure Accounting.** With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

**Right to Request a Restriction.** You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health

care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

**Alternative Communication.** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

**Amendment.** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

**Right to Notification of a Breach.** You will receive notifications of breaches of your unsecured protected health information as required by law.

**Electronic Notice.** You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

### **Questions and Complaints**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Please place your requests, concerns, comments into writing and mail them to our Privacy Officer, Joel C. Scalera.

1400 Dixon Blvd. Cocoa, FL 32922 (321) 636-8120  
33 Suntree Place Suite A, Melbourne, FL 32940 (321) 259-3283

Revised September 15, 2013

Joel C. Scalera DDS PA

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## Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgment\*

I have received a copy of this office's Notice of Privacy Practices.

I permit disclosure of my health information with my: Please write name(s)

\_\_\_ Spouse:

\_\_\_ Parents:

\_\_\_ Others:

Print Your Name: \_\_\_\_\_

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

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

**For Office Use Only    Revised 9/1/2013**

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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other Specify: