PLEASE PRINT

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S LEGAL NAME LAST, FIRST MI	DATE OF BIRTH	SEX	SSN(US) / SIN(CAN)

PREFER TO BE CALLED	HOME PHONE #	CELL PHONE #

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

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

WORK ADDRESS STREET APT# CITY STATE ZIP/POSTAL CODE	WORK PHONE #

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

SPOUSE'S WORK ADDRESS STREET APT# CITY STATE ZIP/POSTAL CODE	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	☐	☐

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	SSN(US) / SIN(CAN)
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS	

SECONDARY COVERAGE ☐ YES ☐ NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S BIRTHDAY	SSN(US) / SIN(CA)
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 (1) any available insurance benefits to be paid directly to my dentist, (2) the release of my dental health care information in connection with any insurance claim for such care, (3) my dentist to use my dental records in any professional manner that he/she so determines, (4) the making of videotapes, photographs, and x-rays of the dental treatment that I receive before, during and after such treatment (collectively "My Images"), and (5) my dentist to use My Images in scientific papers, demonstrations and/or presentations without compensation to me. If I am signing this form as the guardian of a patient then the above authorization is on behalf of such patient.

I acknowledge and agree that if certain costs of my dental care is not covered by insurance, I am financially responsible and obligated to pay my dentist such uninsured cost in accordance with the payment terms and policies of my dentist. If I am signing this form as the guardian of the dentist's patient, the dentist agrees that my signature does not make me personally liable for the payment of any uninsured costs.

Finally, I by signing below I acknowledge my understanding of the risks and limitations involved with the dental treatment that I am to receive or that the patient is to receive if I am signing as such patient's guardian.

SIGNATURE - PATIENT / GUARDIAN	DATE
WITNESS 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
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) __	☐	☐

	YES	NO
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 _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (i.e. 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_____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco _	☐	☐
54. considered a touchy / sensitive person _____	☐	☐
55. often unhappy or depressed_____	☐	☐
56. FEMALE - taking birth control pills _____	☐	☐
57. FEMALE - pregnant _____	☐	☐
58. MALE - prostate disorders _____	☐	☐

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 _____

ASA _____ (1-6)

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) [___] _____	☐	☐
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 you have lost bone 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, sweets, or avoid brushing any part of your mouth? _____	☐	☐
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 have more than one 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 _____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)_____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a late charge may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____Date_____Witness_____

Patient/Responsible Party's Signature_____

Relationship to Patient_____

JOHN P. COURTNEY, JR., D.D.S. / CHAD M. KAMEL D.D.S

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

NAME:_____
ADDRESS:_____**CITY**_____**ST.**_____**ZIP**____
TELEPHONE: (___)_____**CELL#(___)**_____
BUSINESS TELEPHONE(___)_____**EMAIL:**_____
SOCIAL SECURITY#:_____

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. We reserve the right to share all information relating to your treatment with your immediate family. **We reserve the right to contact your previous or current dentist, dental specialists, and medical doctors to discuss your dental and medical treatment. In order to treat patients at the highest standard of care, we will need to gather and discuss your dental and medical history and treatment plans with others in the dental and medical profession.** Please list any dentist, dental specialist, and medical doctors you would like for us to avoid contacting.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. I release, hold harmless and agree to indemnify **John P. Courtney, D.D.S., Chad M Kamel D.D.S.,** the employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this consent, I specifically authorize **John P. Courtney, D.D.S.,** or **Chad M. Kamel D.D.S.,** to use and disclose verbally, by mail, fax, or unencrypted e-mail, the following types of super-confidential information as stated in the Notice of Privacy Practices.

Initial where Appropriate:
___HIV records) including HIV tests results) and sexually transmissible diseases___
___Alcohol and substance abuse diagnosis and treatment records_____
___Psychotherapy records

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our Privacy Officer:

Christina Cano from the office of Dr. John P. Courtney
2600 N. Military Trail, Suite 305, Boca Raton, Fl 33431
Tel: (561) 997-8102 Fax: (561) 997-5974

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Privacy Officer Listed Above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practice. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operation.

Signature_____**Date**_____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Representative:_____Relationship to Patient_____