CONFIDENTIAL INFORMATION QUESTIONNAIRE

Last Name: _____ First Name: _____ Chart #: _____

PATIENT INFORMATION

Patient Name _____ Preferred Name _____

Social Security # _____ Sex ☐M ☐F Age _____ Date of Birth _____

Under Age 18? ☐Yes ☐No If yes, Guardian Name _____

Address _____
Street *City* *State* *Zip Code*

Home # _____ Mobile # _____ Email _____

Drivers License# *(Patient/Guardian)* _____ Issuing State _____

Marital Status ☐S ☐M ☐W ☐D Spouse Name _____

Employer *(Patient/Guardian)* _____ Occupation: _____ Contact # _____

Work Address _____
Street *City* *State* *Zip Code*

Who can we thank for referring you to our office? _____

Other family Members that are patients here _____

EMERGENCY CONTACT

1. Name _____ Relationship _____

Home # _____ Mobile # _____ Work # _____

2. Name _____ Relationship _____

Home # _____ Mobile # _____ Work # _____

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 MOBILE PHONE	☐	☐
CONTACT ME AT WORK	☐	☐
CONTACT ME VIA EMAIL	☐	☐
LEAVE MESSAGES ON MY HOME VOICEMAIL/ANSWERING MACHINE	☐	☐
LEAVE MESSAGES ON MY MOBILE PHONE VOICEMAIL	☐	☐
LEAVE MESSAGES ON MY WORK VOICEMAIL/ANSWERING MACHINE	☐	☐

INSURANCE AND FINANCIAL INFORMATION

PRIMARY DENTAL INSURANCE

Insurance Co. _____ Phone # _____

Subscriber _____ Relation to Patient: ☐Self ☐Spouse ☐Dependent

Member ID# _____ Group# _____ Date of Birth _____

Home # _____ Mobile # _____ Email _____

Address _____

Street *City* *State* *Zip Code*

SECONDARY DENTAL INSURANCE

Insurance Co. _____ Phone # _____

Subscriber _____ Relation to Patient: ☐Self ☐Spouse ☐Dependent

Member ID# _____ Group# _____ Date of Birth _____

Home # _____ Mobile # _____ Email _____

Address _____

Street *City* *State* *Zip Code*

RELEASE INFORMATION

You may discuss my healthcare with:

HEALTHCARE PROVIDERS..... **YES** **NO** INSURANCE COMPANIES..... **YES** **NO**

OTHER _____ **YES** **NO**

Name *Relationship* *Contact #*

OTHER _____ **YES** **NO**

Name *Relationship* *Contact #*

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 for any of my dental health care insurance claim, (3) the use of my dental records by my dentist in any professional manner that he/she determines, and (4) the making of photographs and x-rays of my dental care treatment (collectively "My Images"). I agree that to the extent the cost of the dental care provided by my dentist is not covered by insurance, I am obligated to pay him/her such uninsured cost (the "Uninsured Costs") in accordance with his/her payments terms and policies. Finally, I certify that I have read or had read to me the contents of this form and understand the risks and limitations involved with the dental treatment that I am to receive.

_____ _____

SIGNATURE (PATIENT/GUARDIAN) DATE

_____ _____

WITNESS SIGNATURE DATE

If the above named Patient is a minor or unable to pay the his/her Uninsured Costs, the undersigned agrees to guaranty the payment of such Uninsured Costs to the Patient's dentist in accordance with his/her payment terms and policies.

_____ _____

SIGNATURE (GUARANTOR OF PATIENT) DATE

MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Physician Name/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: **Y N**

1. Hospitalization for illness or injury (if yes, list below*) _____ ❑ ❑
2. An allergic reaction to
   - ❑ Aspirin, ibuprofen, acetaminophen, codeine
   - ❑ Penicillin
   - ❑ Erythromycin
   - ❑ Tetracycline
   - ❑ Sulfa
   - ❑ Local anesthetic
   - ❑ Fluoride
   - ❑ Metals; nickel, gold, silver, other: _____
   - ❑ 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 (if yes, list below*) _____ ❑ ❑
8. Rheumatic or scarlet fever _____ ❑ ❑
9. Blood pressure issues (please circle: HIGH or LOW) _____ ❑ ❑
10. 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) _____ ❑ ❑
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 use (If yes, list no. drinks/week: _____) _____ ❑ ❑
47. Recreational drug use _____ ❑ ❑

ARE YOU:

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 used smokeless tobacco ___ ❑ ❑
54. Taking birth control pills _____ ❑ ❑
55. Currently pregnant _____ ❑ ❑
56. Prostate disorders _____ ❑ ❑

List illnesses you are currently receiving treatment for: _____

Describe any current medical treatment, impeding a surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment (i.e. Botox, Collagen Injections):

_____

_____

*List Information: _____

_____

List all medications, supplements, and/or vitamins taken within the last two years. If additional space is needed, please attached list.

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

Name: _____ Date of Birth: _____

Previous Dentist: _____ How long have you been a patient? (MO/YR): _____

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

How would you rate the condition of your mouth? _____ Excellent _____ Good _____ Fair _____ Poor

WHAT IS YOUR IMMEDIATE CONCERN? _____

	YES	NO
PERSONAL HISTORY		
1. Are you fearful of dental treatment? If yes, 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 (without 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 three 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 a void brushing any part of your teeth? _____	❑	❑
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 a 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 (i.e. pain, sounds, limited opening, locking, popping)? _____	❑	❑
22. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, protein bars, or other hard, dry foods? _____	❑	❑
23. Have your teeth changed in the last 5 years, becoming shorter, thinner, or worn? _____	❑	❑
24. Are your teeth becoming more crooked, crowded, or overlapped? _____	❑	❑
25. Are your teeth developing spaces or becoming looser? _____	❑	❑
26. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	❑	❑
27. Do you clench your teeth in the daytime or make them sore? _____	❑	❑
28. Do you wear, or have you ever worn a bite appliance? _____	❑	❑
SMILE CHARACTERISTICS		
29. Is there anything about the appearance of your teeth that you would like to change? _____	❑	❑
30. Have you ever whitened (bleached) your teeth? _____	❑	❑
31. Have you been disappointed with the appearance of previous dental work? _____	❑	❑

_____ _____

PATIENT'S SIGNATURE DATE

_____ _____

DOCTOR'S SIGNATURE DATE

STATEMENT OF PRIVACY PRACTICES

THIS STATEMENT DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN 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 applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Statement of Privacy Practices, our legal duties, and your rights concerning your health information. We must follow the Statement of Privacy Practices that are described within while it is in effect. This Statement of Privacy Practices takes effect 07/13/2018 and will remain in effect until we replace it.

We reserve the right to change the terms of this Statement of Privacy Practices at any time, provided such changes are permitted by applicable law. We reserve the right to make changes to the terms for all health information that we maintain, health information we created, or health information we received before changes were created. Before we make a significant change in the Statement of Privacy Practices, we will make the new Statement of Privacy Practices available upon request.

You may request a copy of our Statement of Privacy Practices at any time. For more information about the Statement of Privacy Practices, or for additional copies, please contact us using the information listed at the end.

USES AND DISCLOSURES OF HEAL TH 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 physician or other healthcare provider providing treatment to you.

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 Authorizations: In addition to our use of your health information for treatment, payments 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. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the Statement of Privacy Practices.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of the Statement of Privacy Practices. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you authorize us to do so.

Person 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, of your location, your general condition, or 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 circumstances, we will disclose health information based on a determination using our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled 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.

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

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

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemails messages, postcards, or letters).

PATIENT RIGHTS

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. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Statement of Privacy Practices. We may charge a reasonable cost-based fee for expenses such as copies and staff time. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of the Statement of Privacy Practices for a full explanation of our fee structure.

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. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternate means or to alternative locations, which must be requested in writing. Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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 needs amended. We may deny your request under certain circumstances.

Electronic Notices: If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form.

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 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 the Statement of Privacy Practices. 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.

CONTACT INFORMATION

Officer: Christopher Kaouk, DMD, PA
Telephone: 407-869-0001
Fax: 407-755-4399
E-mail: ChristopherKaoukDMD@gmail.com
Address: 100 Lake Shore Drive, Ste. 112, Altamonte Springs, FL 32714

Christopher Kaouk, DMD, PA

100 Lake Shore Dr. Ste. 112
Altamonte Springs, FL 32714

Office: (407) 869-0001
Fax: (407) 755-4399

Email: ChristopherKaoukDMD@gmail.com

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I, **(PATIENT NAME)** _____ acknowledge I have received a copy of the Statement of Privacy Practices for the office of Christopher Kaouk, DMD, PA. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also available in the facility.

Christopher Kaouk, DMD, PA reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If the 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 on to be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices. **I hereby authorize disclosure of my protected health care information to:**

Full Legal Name	*Relationship*	*Contact #*
Full Legal Name	*Relationship*	*Contact #*
Full Legal Name	*Relationship*	*Contact #*

_____ _____

Signature of Patient/Guardian Date