CONFIDENTIAL INFORMATION QUESTIONNAIRE

Name_____

Address_____

City_____ State_____ Zip Code_____

Home Telephone _____ Work Telephone_____

Cell Phone _____ Fax _____ E-mail _____

Birth Date _____ Social Security # _____Marital Status ☐M ☐S ☐D ☐W

Patient's Employer _____ Occupation _____

IF MARRIED

Spouse's Name_____ Spouse's Employer _____

Spouse's Occupation _____ Spouse's Work Phone _____

Person We May Contact in Case of an Emergency (Not Living in Family Home)

Name _____ Relationship _____

Home Phone_____ Work Phone _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

☐ Our Sign ☐ Internet ☐ Location ☐ Dentist/Doctor (Name) _____

☐ Advertisement ☐ Yellow Pages ☐ Staff Member/ Patient (Name) _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Dr. John Fish and/or his staff to disclose protected health information to the following person's _____.

Please initial each item that is subject to this authorization:

_____ Leave information on the voice mail or answering machine at home and/or work
_____ Leave information with my spouse
_____ Mail appointment reminder postcards to home address
_____ Supply requested information or x-rays to insurance carrier(s)
_____ Leave information with the following persons: _____

Description of information to be released (please initial appropriate items):

_____ Date and time of my next appointment and with whom
_____ Information results from any tests or x-rays
_____ Information regarding any necessary pre-medication
_____ Other information as described: _____

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization. The permitted use of the information is to inform the patient.

Rights of the Patient

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and my no longer be protected by federal or state law.* I understand that I have the right to revoke this authorization by sending written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effected going forward. I understand that I have the right to inspect or copy protected health information as described in this document. I can do this by written notification to John M Fish DDS, PA, P.O. Box 665, Hildebran, NC 28637.

_____ _____

Signature of Patient **Date**

MEDICAL HISTORY

Sex _____ Height _____ Weight _____ Age _____

1. What is your estimate of you general health? Poor ☐ Fair ☐ Good ☐ Excellent ☐
2. Most recent physical (month/year)_____ Purpose _____
3. Name and city of your physician? _____
4. Name and city of any medical specialists? _____
5. Describe any serious illnesses or operations_____
6. Describe any current medical treatment or pending surgery_____

_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (Please check appropriate box)

1. Allergic or adverse reaction to:

	YES	NO	
	☐	☐	Aspirin? _____
	☐	☐	Ibuprofen? _____
	☐	☐	Acetaminophen (Tylenol)? _____
	☐	☐	Penicillin? _____
	☐	☐	Erythromycin? _____
	☐	☐	Other antibiotics? _____
	☐	☐	Barbiturates or sedatives? _____
	☐	☐	Codeine or hydrocodone? _____
	☐	☐	Other narcotics? _____
	☐	☐	Fluoride? _____
	☐	☐	Metals (gold, stainless steel)? _____
	☐	☐	Latex rubber? _____
	☐	☐	Any other medications? If so, what? _____
2.	☐	☐	Heart attack? If so, when? _____
3.	☐	☐	Stroke? If so, when? _____
4.	☐	☐	Rheumatic fever or Scarlet fever? _____
5.	☐	☐	Heart murmur? Do you take antibiotics before dental treatment? _____
6.	☐	☐	High blood pressure? If so, list medication(s):_____
7.	☐	☐	Low blood pressure? If so, list medication(s):_____
8.	☐	☐	Cardiac pacemaker? _____
9.	☐	☐	Artificial heart valves? _____
10.	☐	☐	Heart Surgery? _____
11.	☐	☐	Anemia or any blood disorder? If so, list medication(s):_____
12.	☐	☐	Blood transfusion? _____
13.	☐	☐	Prolonged bleeding after any surgery? _____
14.	☐	☐	Sinus problems?_____
15.	☐	☐	Tuberculosis? _____
16.	☐	☐	Asthma? _____
17.	☐	☐	Emphysema? _____
18.	☐	☐	Chronic bronchitis? _____
19.	☐	☐	Kidney disease? _____
20.	☐	☐	Venereal disease? _____
21.	☐	☐	HIV or AIDS? _____
22.	☐	☐	Jaundice? _____
23.	☐	☐	Hepatitis (Type _____) If so, when? _____
24.	☐	☐	Stomach or duodenal ulcers? If so, list medication(s):_____
25.	☐	☐	Acid reflux or hiatal hernia? If so, list medication(s):_____
26.	☐	☐	Thyroid or parathyroid disease? If so, list medication(s):_____
27.	☐	☐	MRSA? _____

	YES	NO	
28.	☐	☐	Hormone deficiency? If so, list medication(s):_____
29.	☐	☐	High cholesterol? _____
30.	☐	☐	Diabetes? If so, list medication(s):_____
31.	☐	☐	Arthritis? _____
32.	☐	☐	Artificial joints? Do you take antibiotics before dental treatment? _____
33.	☐	☐	Osteoporosis? _____
34.	☐	☐	Taken bisphosphonate drugs (Actonel, Fosamax, Boniva) past or present?_____
35.	☐	☐	Glaucoma? _____
36.	☐	☐	Contact lenses? _____
37.	☐	☐	Head or neck injuries? _____
38.	☐	☐	Epilepsy or seizures? If so, list medication(s):_____
39.	☐	☐	Emotional problems? _____
40.	☐	☐	Psychiatric treatment? If so, when? _____
41.	☐	☐	Depression? If so, list medication(s):_____
42.	☐	☐	Alcohol/drug dependency? _____
43.	☐	☐	Cold sores or fever blisters? _____
44.	☐	☐	Lumps or swelling in your mouth? _____
45.	☐	☐	Do you have a family history of oral cancer? _____
46.	☐	☐	Hives, hay fever, or skin rash? _____
47.	☐	☐	Tumor or abnormal growth? _____
48.	☐	☐	Radiation therapy? _____
49.	☐	☐	Chemotherapy? _____
50.	☐	☐	Often frightened or exhausted? _____
51.	☐	☐	Subject to frequent headaches? _____
52.	☐	☐	Considered a touchy person? _____
53.	☐	☐	Easily upset or irritated? _____
54.	☐	☐	A tobacco user? If so, how much? _____
55.	☐	☐	An alcohol user? If so, how much? _____
56.	☐	☐	Do you snore? _____
57.	☐	☐	Do you gasp for breath during sleep? _____
58.	☐	☐	Do you use CPAP? _____
59.	☐	☐	Fearful of dental treatment or dental work? _____
60.	☐	☐	A FEMALE and taking birth control pills or hormone therapy? _____
61.	☐	☐	A FEMALE and post menopausal? _____
62.	☐	☐	A FEMALE and pregnant? _____
63.	☐	☐	A MALE with prostate disorders? _____

Please circle any you are taking: garlic, gingko, ginger, ginseng, echinacea, ephedra, kava, St. John's wort, valerian. Please list other medications, supplements or vitamins taken within the last 2 years _____

_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

RESPONSIBILITY AND CONSENT STATEMENT

I authorize and consent to Dr. John Fish obtaining copies of my medical and dental records from my current or previous physicians, dentists, psychologists, and hospitals, or any other medical/dental provider. I expressly authorize any of the foregoing medical care providers or entities to release copies of my records to Dr. Fish, and to discuss care and treatment rendered to me with Dr. Fish. This authorization and consent shall be valid until withdrawn by me, in writing. I understand that Dr. Fish and his staff will always do their best to inform me of the risks, benefits and costs involved with any contemplated treatment.

I give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposes or dental treatment. I also consent to the use of photography, including video taping of informed consent and dental procedures. I understand and acknowledge that I am financially responsible for all services, regardless of insurance coverage.

To the best of my knowledge, the information provided by me in this form is as accurate as possible.

_____ _____

Patient's Signature Date Doctor's Signature Date

Watermark Medical ARES Questionnaire

PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX

First Name	Middle Initial	Last Name

Tally ARES Risk Points

Weight	Pounds	**Age**	Years	Gender: **Male** ◯ **Female** ◯
Height	Feet / Inches		**Neck Size**	Inches
Date of Birth	Month / Day / Year		**ID Number**	Optional

Neck Size
+2 Male ≥16.5
+2 Female≥15.0

Score ☐

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

High blood pressure	Yes ◯	No ◯	Stroke	Yes ◯	No ◯
Heart disease	Yes ◯	No ◯	Depression	Yes ◯	No ◯
Diabetes	Yes ◯	No ◯	Sleep apnea	Yes ◯	No ◯
Lung disease	Yes ◯	No ◯	Nasal oxygen use	Yes ◯	No ◯
Insomnia	Yes ◯	No ◯	Restless leg syndrome	Yes ◯	No ◯
Narcolepsy	Yes ◯	No ◯	Morning Headaches	Yes ◯	No ◯
Sleeping Medication	Yes ◯	No ◯	Pain Medication e.g., vicodin, oxycontin	Yes ◯	No ◯

Co-morbidities +1 for each Yes response

Score ☐

Do not assign any points for these eight responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze **1 = slight chance of dozing**
2 = moderate chance of dozing **3 = high chance of dozing**

	0	1	2	3
Sitting and reading	◯	◯	◯	◯
Watching TV	◯	◯	◯	◯
Sitting, inactive, in a public place (theater, meeting, etc)	◯	◯	◯	◯
As a passenger in a car for an hour without a break	◯	◯	◯	◯
Lying down to rest in the afternoon when circumstances permit	◯	◯	◯	◯
Sitting and talking to someone	◯	◯	◯	◯
Sitting quietly after lunch without alcohol	◯	◯	◯	◯
In a car, while stopped for a few minutes in traffic	◯	◯	◯	◯

Epworth Score **TOTAL** the values from all 8 questions,
If 11 or less **Score = 0**
If 12 or more **Score = 2**

Score ☐

Frequency **0 - 1 times/week** **1 - 2 times/week** **3 - 4 times/week** **5 - 7 times/week**

On average in the past month, how often have you snored or been told that you snored?
Never ◯ Rarely ◯ +1 Sometimes ◯ +2 Frequently ◯ +3 Almost always ◯ +4

Do you wake up choking or gasping?
Never ◯ Rarely ◯ +1 Sometimes ◯ +2 Frequently ◯ +3 Almost always ◯ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?
Never ◯ Rarely ◯ +1 Sometimes ◯ +2 Frequently ◯ +3 Almost always ◯ +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?
Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯ Almost always ◯

Assign points for each of the first three responses

☐
☐
☐

Signature	Area Code	Phone Number	**Total all 6 boxes from above**	**Point Total**
			If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)	☐

Dr. John M. Fish
General Dentist
Implant, Cosmetic & Sedation Dentistry
Exceptional Care For Confident Smiles

APPOINTMENT CONFIRMATIONS & CORRESPONDENCE

What is your preferred method for correspondence?

___ Home Address: _____

___ E-mail: _____

What is your preferred method for appointment confirmation?

(Please list in order of preference with "1" being the highest)

___ Home Phone: _____

___ Work Phone: _____

___ Cell Phone: _____

___Text Message: _____

___ E-mail: _____

Patient Signature_____

Date_____

607 US 70 Highway • P.O. Box 665 • Hildebran, NC 28637
Phone: (828) 397-5514 • Fax: (828) 397-3980 • Website: www.SmileHere.com

Dr. John M. Fish
General Dentist
Implant, Cosmetic & Sedation Dentistry
Exceptional Care For Confident Smiles

OFFICE POLICY STATEMENT

TO OUR VALUED PATIENTS:

We have three important office policies designed to benefit all of our patients. We believe that these policies will prevent any misunderstandings regarding our mutual expectations. Please read them carefully and if you have any questions, feel free to discuss them with one of our staff members. If you understand our policies, please indicate by signing at the bottom of this page.

***Commitment to Treatment Policy*:**

We will not begin any course of treatment without your full knowledge and consent. Naturally, it is always in your best interest to complete any course of treatment that we begin. Incomplete treatment can result in problems, complications, and misunderstandings. It can also lead to loss of teeth and further disease. It is important for you to understand your commitment to both starting and completing your treatment plan.

***Commitment to Financial Agreement*:**

We will not begin any treatment without making careful financial arrangements in advance. Our arrangements are made directly with you regardless of any third party insurance coverage. **WE DO NOT ACCEPT ANY PAYMENTS FOR OUR SERVICES DIRECTLY FROM YOUR INSURANCE COMPANY.** After our financial agreement has been established, by signing below you agree to fulfill your commitment to our office promptly and completely.

***Commitment to Appointment Policy*:**

Our appointment times are reserved **just for you**. We are sensitive to emergencies and realize that occasional changes in our schedule or yours may be necessary. **However, we reserve the right to charge any patient for appointments that are broken or cancelled with less than 24 hours notice. We also reserve the right to dismiss any patient who fails two or more appointments.**

PATIENT SIGNATURE _____ STAFF MEMBER _____ DATE

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Implant, Cosmetic & Sedation Dentistry
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MISSION STATEMENT

Our practice mission is to provide each person who contacts our office an opportunity for optimal dental health, comfort, function, and appearance. The primary means by which this will be done is through a complete examination. This must include a thorough discussion of each patient's special dental needs and development of a goal oriented treatment plan that addresses the causes as well as effects of dental disease.

We continually strive to maintain our position as a regional standard bearer for implant, cosmetic and restorative dentistry. Our practice is focused upon successful long-term relationships rather than crisis care. Essential to this is our ongoing commitment to quality, honesty, integrity, and service.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT NAME AND ADDRESS_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

_____

For Office Use Only

_____

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- **An emergency existed and a signature was not possible at the time.**
- **The Individual refused to sign**
- **A copy was mailed with a request for a signature by return mail.**
- **Unable to communicate with the patient for the following reason:**

  _____
- **Other:**_____

  _____

Prepared by: _____

Signature: _____

Date: _____

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Phone: (828) 397-5514 • Fax: (828) 397-3980 • Website: www.johnfishdds.com

Conduct Your No-Cost Consultation

Schedule Your Examination

Fee is Due When Scheduling Exam to Reserve Appointment

Perform Your Comprehensive Exam

CT Scan, Full Mouth X-Rays, Complete Review of Teeth, Gums, Bite, Jaw Joints, Sinuses, Air Way, Oral Cancer Evaluation and Photos

Review Our Findings & Discuss Your Options