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

CONFIDENTIAL INFORMATION QUESTIONAIRE

Name: _____ **Date of Birth**: _____

Address:_____**City**:_____**State**:_____

Zip:_____ **Home Telephone**:_____ **Cell Phone**: _____

Email: _____ **Marital Status (circle)**: S M D W

Employer: _____**Occupation**:_____

Preferred Pharmacy (Name & Location):_____ **Number**:_____

IF MARRIED:

Spouse's Name: _____ Spouse's number:_____

PERSON WE MAY CONTACT IN CASE OF EMERGENCY (*IF NOT SPOUSE*):

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

How did you find out about our office?

☐ Our Sign ☐ Internet (Google) ☐Location ☐ Social Media (FaceBook) ☐Other_____

☐ Dentist/Doctor_____ ☐ Advertisement ☐ Staff/ Patient _____

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

_____Supply request 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

_____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 may 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 affected 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, and P.O. Box 665, Hildebran, NC 28637.

_____ _____

Patient Signature ***Date***

MEDICAL HISTORY:

Sex:_____ Height:_____ Weight:_____ Age:_____

1. What is your estimate of your general health (circle one)? Poor Fair Good Excellent

2. Most recent physical (month/year)_____Purpose_____

3. Name and City of your physician? _____

Phone:_____

4. Name and City of your medical specialist:_____

Phone:_____

5. Describe any serious illnesses or operations:_____

6. Describe any current medical treatment or pending surgery:_____

Have you ever had an allergic or adverse reaction to (Please check appropriate box):

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?_____

YES NO Have you ever had any of the following? *(Please check appropriate box):*

- ☐ ☐ Heart attack? If so, when?_____
- ☐ ☐ Stroke? If so, when?_____
- ☐ ☐ Rheumatic fever or Scarlet fever?_____
- ☐ ☐ Heart murmur? Do you take antibiotics for dental treatment?_____
- ☐ ☐ High blood pressure? If so, list medication(s):_____
- ☐ ☐ Low blood pressure? If so, list medication(s):_____
- ☐ ☐ Cardiac pacemaker?_____
- ☐ ☐ Artificial heart valves?_____
- ☐ ☐ Heart surgery?_____
- ☐ ☐ Anemia or any blood disorder? If so, list medication(s): _____
- ☐ ☐ Blood transfusion:_____
- ☐ ☐ Prolonged bleeding after any surgery?_____
- ☐ ☐ Sinus problems?_____
- ☐ ☐ Tuberculosis?_____
- ☐ ☐ Asthma?_____
- ☐ ☐ Emphysema?_____
- ☐ ☐ Chronic bronchitis?_____
- ☐ ☐ Kidney disease?_____
- ☐ ☐ Venereal disease?_____
- ☐ ☐ HIV or AIDS?_____

- [ ] Jaundice?
- [ ] Hepatitis (Type____) If so, When?
- [ ] Stomach or duodenal ulcers?
- [ ] Acid Reflux or hiatal hernia?
- [ ] Thyroid or parathyroid disease?
- [ ] MRSA?
- [ ] Hormone deficiency? Medication(s)s:
- [ ] High Cholesterol?
- [ ] Diabetes? Medication(s):
- [ ] Arthritis?
- [ ] Artificial Joints? Do you pre-medicate for dental appointments with antibiotics?
- [ ] Osteoporosis?
- [ ] Taken Bisphosphonate drugs (Actonel, Fosamax, Boniva) past or present?
- [ ] Glaucoma?
- [ ] Contact Lenses?
- [ ] Head and neck injuries?
- [ ] Epilepsy or seizures? If so, medication(s):
- [ ] Emotional problems:
- [ ] Psychiatric Treatment? If so, when?
- [ ] Depression?
- [ ] Alcohol/drug dependency?
- [ ] Cold sores or fever blisters?
- [ ] Lumps or swelling in your mouth?
- [ ] Do you have a family history of oral cancer?
- [ ] Hives, Hay fever, or skin rash?
- [ ] Tumor or abnormal growth?
- [ ] Radiation therapy?
- [ ] Chemotherapy?
- [ ] Often frightened or exhausted?
- [ ] Subject to frequent headaches?
- [ ] Considered a touchy person?
- [ ] Easily upset or irritated?
- [ ] A tobacco user?
- [ ] Do you Vape or use Cannabis? How much?
- [ ] An alcohol user? How much?
- [ ] Do you snore?
- [ ] Do you gasp for air during sleep?
- [ ] Do you use a CPAP?
- [ ] Fearful of dental treatment or dental work?
- [ ] A Female taking birth control pills or hormone therapy?
- [ ] A Female post menopausal?
- [ ] A Female pregnant?
- [ ] A male with prostate disorders?

Please circle any medications 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 two years ***or*** provide us with a list:

_____

_____

_____

_____

_____

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 forgoing 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.

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

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

Patient Signature:_____ Date:_____

Dr. Signature:_____ Date:_____

OUR PROCESS

Step 1:
Conduct your no-cost Consultation

Step 2:
Schedule your Examination
Fee is Due When Scheduling Exam to Reserve Appointment

Step 3:
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

Step 4:
Review Our Findings & Discuss your Options

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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 but 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.

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.It is recommended that you contact your insurance provider to see what all services they will cover per your plan.** 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 or your schedule 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.**

Continuing Care: Please note that all Recare appointments with our Hygienist have a fee for the services provided during this visit. Please note that all x-rays, CT scans, fluoride varnish, Dr. Fish's exam, products and other additional services will also have additional fees that will be quoted before being performed. Please note: We do not accept insurance as a form of payment. It is recommended that you contact your insurance provider to see what all services they will cover per your plan.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Patient Signature:_____ Date:_____