NEW PATIENT INTERVIEW

What is your primary dental concern?

How long since your last dental visit?

If you could change your smile, what would it be?

On a scale of 1-10 (1 being "bad," 10 being excellent), how would you rate the condition of your teeth?

On a scale of 1-10, how would you like for it to be?

What is the most important thing to you about your teeth?

Do you with your teeth were whiter?

Do you expect to keep your teeth for a lifetime?

How would you like your teeth to be 15 years from now?

How often do you brush? Floss? Manual/Electric toothbrush?

Do your gums bleed?

Is there anything that you eat or drink that could be contributing to the decline of your teeth? Sugar? Acidic fruits or drinks?

What is your family history of dentistry? Do you have family members who wear dentures or partials? Any history of gum disease?

Is there anything happening in your life that could influence your treatment?

In our work together, what would you like to accomplish?

Does insurance have a deciding factor in achieving your goals?

Please rank the following in order of importance Quality____ Service ____ Time____ Price____

How did you find out about our practice?

What made you select our office?

Who may we thank for referring you to our office?

HIPPA PRIVACY ACT

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:
Detailed description of the information to be released:
To whom may the information be released [name(s) or class(es) of recipients]:
The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):
Expiration date or event relating to the individual or purpose for the release:
It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.
If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.
When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.
[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]
I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.
Dated_____ Patient signature_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:
Relationship to Patient _____Print Name_____
Source of Authority_____

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

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.