Setter Periodontics
OF PORTLAND

Michael K. Setter D.D.S., M.S.D.
Diplomate, American Board of Periodontology
Fellow, International Congress of Oral Implantology

Confidential Information Questionnaire

Legal Name	Last	First	MI	Preferred Name	Date of Birth	Gender

Contact Info	E-mail	Cell Phone	Home Phone	Best Method of Contact

Address	Street	Unit #	City	State	Zip

Marital Status	Employer	Whom Can We Thank For Referring You To Our Office?

Emergency Contact Name	Relationship	Phone Number

Methods of Communication

Unless you indicate a preference to not be contacted by a method, our office uses multiple methods of communication with our patients.

Request for Confidential Communication

AS MY DENTAL CARE PROVIDER, YOU MAY DO THE FOLLOWING WITH MY PERMISSION

	YES	NO
Contact me at home/Leave messages on my home voicemail	☐	☐
Contact me via cell phone/Leave messages on my cell phone voicemail.	☐	☐
Contact me via e-mail.	☐	☐

Confirmations

DO YOU PREFER A CONFIRMATION CALL?

☐No, it is unnecessary ☐Yes, it is a helpful reminder I prefer: ☐Phone ☐Text ☐E-mail

_____ initials

I provide Setter Periodontics and Dental Implants and their staff consent to discuss limited Personal Health Information with anyone who transports me to and from an appointment when I am sedated. Examples might include how your treatment went or instructions for any post-treatment care.

Release Information

YOU MAY DISCUSS MY HEALTHCARE WITH:

	YES	NO	OTHERS (PLEASE PRINT):
Health Care Providers	☐	☐	1.
Insurance Companies	☐	☐	2.
			3.

Notice of Privacy Practices

_____ initials

I have received a copy of the Notice of Privacy Practices. I hereby authorize, as indicated by my initials, Setter Periodontics and Dental Implants to use and disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the patient consent form.

Setter Periodontics
OF PORTLAND

Michael K. Setter D.D.S., M.S.D.
Diplomate, American Board of Periodontology
Fellow, International Congress of Oral Implantology

Dental Benefits and Financial Information

Insurance Company Name		Insurance Company Phone	
Subscriber's Name	Relationship	Subscriber's Birth Date	ID #
Group/Program Number	Employer (if different from above)		
Secondary Insurance Company Name (if applicable)		Insurance Company Phone	
Subscriber's Name	Relationship	Subscriber's Birth Date	ID #
Group/Program Number	Employer (if different from above)		

Assignment and Release

To the best of my knowledge, the above information is correct and I am responsible to inform the office of any changes. 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 are 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. I understand that treatment recommendations are based on my dental needs and desires and are not a reflection of dental benefits. Dr. Setter will not compromise any care based on insurance benefits and Setter Periodontics will assist me in the processing of my claims but is not responsible for their policies, decisions, or disbursement of funds.

Finally, 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 of Patient/Guardian	Date

Medical/Dental History

1. Hospitalization(s) for illness or injury: _____
2. Allergic reactions to:

   ☐ aspirin, ibuprofen, acetaminophen, codeine
   ☐ penicillin ☐ erythromycin
   ☐ tetracycline ☐ sulfa
   ☐ local anesthetic ☐ latex
   ☐ other_____

   Phamacy Name and Location:

   _____

3. Are you in good health? . . . . . Yes ☐ No ☐
4. Date of last physical: _____ Are you currently being treated by a physician? . . . . . Yes ☐ No ☐
5. Please list your current prescription drugs or medications:

6. Please list any over-the-counter preparations or medications (e.g. aspirin, vitamins, supplements):

7. Indicate which of the following you have had or have at the present:

Heart disease or attack	Yes	☐ No ☐	Allergies/Hives	Yes	☐ No ☐	Prolonged bleeding	Yes	☐ No ☐
High blood pressure	Yes	☐ No ☐	Sinus troubles	Yes	☐ No ☐	Immune System Disorder	Yes	☐ No ☐
Angina (chest pain).	Yes	☐ No ☐	Thyroid disease.	Yes	☐ No ☐	AIDS/HIV Positive	Yes	☐ No ☐
Congenital heart lesions	Yes	☐ No ☐	Liver disorder.	Yes	☐ No ☐	Fainting or dizziness	Yes	☐ No ☐
Artificial heart valve	Yes	☐ No ☐	Hepatitis	Yes	☐ No ☐	Epilepsy or seizures.	Yes	☐ No ☐
Heart pacemaker	Yes	☐ No ☐	Diabetes	Yes	☐ No ☐	Cancer.	Yes	☐ No ☐
Heart surgery	Yes	☐ No ☐	Hemoglobin A1c _____			Type _____		
Joint replacement	Yes	☐ No ☐	Arthritis.	Yes	☐ No ☐	Chemotherapy.	Yes	☐ No ☐
Stroke	Yes	☐ No ☐	Osteoporosis	Yes	☐ No ☐	Radiation treatment.	Yes	☐ No ☐
Kidney disorder.	Yes	☐ No ☐	Glaucoma.	Yes	☐ No ☐	Mental disorder	Yes	☐ No ☐
Ulcers	Yes	☐ No ☐	Cold sores	Yes	☐ No ☐	Anxiety or depression	Yes	☐ No ☐
Emphysema	Yes	☐ No ☐	Blood disease	Yes	☐ No ☐	Drug addiction.	Yes	☐ No ☐
Asthma	Yes	☐ No ☐	Anemia.	Yes	☐ No ☐	Alcohol addiction	Yes	☐ No ☐

8. Do you have any disease, condition, or problem not listed? . . . . . Yes ☐ No ☐
   If yes, please explain _____
9. Do you currently or have you in the past taken Fosamax, Actonel, Boniva, Prolia, or Reclast for osteoporosis or were you treated with Zometa or Aredia for chemotherapy? . . . . . Yes ☐ No ☐
10. Do you currently smoke (including e-cigarettes, vape, marijuana, or smokeless tobacco? . . . . . Yes ☐ No ☐
    How much? . . . . . _____
11. Date of last dental visit: . . . . . _____
12. Have you had any problems associated with dental treatment? . . . . . Yes ☐ No ☐
13. Have you ever had periodontal treatment? . . . . . Yes ☐ No ☐
14. Do you have any family history of gum disease or tooth loss? . . . . . Yes ☐ No ☐
15. Do you clench or grind your teeth? . . . . . Yes ☐ No ☐
16. Do you have any head, neck, jaw, or mouth pain? . . . . . Yes ☐ No ☐
17. Do you have any specific questions or concerns about your oral health? . . . . . Yes ☐ No ☐
    If yes, please explain

    _____

WOMEN

18. Are you currently pregnant? . . . . . Yes ☐ No ☐
19. Are you taking birth control pills? . . . . . Yes ☐ No ☐

Signature - Patient/Guardian	Date
Signature - Doctor	Date