



Welcome

In order to ensure your maximum oral health and allow us to prescribe the proper medications. It is very important that we know all medical and dental information about you. Please check every box on pages of this form, even if the answer is N/A (not applicable). This information will be kept in the strictest confidence.

You also should know that changes in other parts of your body may affect the oral cavity and what dental treatment can be done, even if they seem unconnected. Cardiac (heart problems, artificial joints and diabetes are just some examples.

Will you please inform the dentist or the staff at the beginning of each new office visit if your medical or dental conditions changed since your last saw you? Yes No. Thank You.

PATIENT INFORMATION

Date: _____

Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

I prefer to be called: Mr. Mrs. Miss Other _____

Birthdate: _____ Gender: M F Age: _____

Single Married Widowed Separated Divorced

Patient SS#: _____ - _____ - _____

If patient is a minor, give parent's or guardian's name:

Occupation: _____

Employer: _____

Spouse's Name: _____

Spouses Occupation: _____

Spouses Employer: _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account? _____

SS#: _____ Birthdate: _____

Relationship to patient: _____

Insurance Co: _____

Group#: _____

Is patient covered by additional insurance? Yes No

Subscribers name: _____

Insurance Co: _____

Group# _____

PHONE NUMBERS

Home Phone: _____

Work: _____ Ext: _____

Spouse Work: _____

Best time and place to reach you: _____

Family Physicians Name: _____

Physicians Phone: _____

IN CASE OF EMERGENCY, CONTACT (*Specify someone who does not live in your household*)

Name: _____

Relationship: _____

Home Phone: _____

Work Phone: _____

ASSIGNMENT AND RELEASE

I certify that I (or my dependent) have insurance coverage as Indicated and assign directly to this office all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relation To Minor (if applicable)

Date

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

Date of last dental visit _____

Date of last x-rays _____

MARK **YES** OR **NO** TO INDICATE IF YOU PRESENTLY HAVE OR HAD ANY OF THE FOLLOWING

- Bad Breath Yes No
Bite your lips or cheeks regularly Yes No
Bleeding Gums Yes No
Blisters on lips or gums Yes No
Chew on one side of your mouth Yes No
Dry mouth Yes No
Food collection between teeth Yes No
Grinding teeth Yes No
Gums swollen or tender Yes No
Jaw pain or tiredness Yes No
Mouth breathing Yes No
Orthodontic treatment Yes No
Pain around ear Yes No
Periodontal (gum) treatment Yes No
Sensitivity to cold Yes No
Sensitivity to hot Yes No

Have You Experienced:

- Clicking or popping of the jaw? Yes No
Pain (joint, ear, side of face) Yes No
Difficulty opening/closing mouth? Yes No

How often do you floss?

How often do you brush?

Do you require any antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No

Do you like your smile? Yes No

Do you feel nervous about having a dental treatment? Yes No

Have you ever had a bad experience in a dental office? Yes No

If yes, describe _____

Is there anything else about having dental treatment that you would like us to know?

MEDICAL HISTORY

Do you have any of the following diseases or medical problems

- Abnormal Bleeding Yes No
Alcohol/Drug abuse Yes No
Alzheimers Disease Yes No
Anemia Yes No
Arthritis Yes No
Artificial Bones
Joints/Valves Yes No
Asthma Yes No
Blood Transfusion Yes No
Bruise Easily Yes No
Cancer/Chemotherapy Yes No
Colitis Yes No
Diabetes Yes No
Difficulty Breathing Yes No
Emphysema Yes No
Epilepsy Yes No
Fainting Spells Yes No
Frequent Headaches Yes No
Glaucoma Yes No
Hay Fever Yes No
Heart Problems Yes No
Heart Murmur Yes No
Hepatitis Yes No
Hemophilia Yes No
Herpes/Fever Blister Yes No
High Blood Pressure Yes No
HIV+/AIDS Yes No
Hospitalized for any reason Yes No
Joint Replacement Yes No
Kidney Problems Yes No

Your current physical health is
 Good Fair Poor

Are you under the care of a Physician?
 Yes No Please Explain: _____

Are you taking any prescription/over the counter drugs? Yes No
Please List if any: _____

FOR WOMEN:

- Are you taking birth control pills? Yes No
Are you pregnant? Yes No
Are you nursing? Yes No

Do you smoke or use any tobacco in any forms? Yes No

- Liver Disease Yes No
Low Blood Pressure Yes No
Mitral Valve Prolapse Yes No
Nervous/Anxious Yes No
Pacemaker Yes No
Psychiatric /
Psychological Care Yes No
Radiation Treatment Yes No
Rheumatic/Scarlet Fever Yes No
Seizures Yes No
Sinus Problems Yes No
Thyroid Problems Yes No
Tuberculosis (TB) Yes No
Tumors or Growths Yes No
Ulcers Yes No
Venereal Disease Yes No

Do you have or had any disease condition, or problem not listed?

Yes No

Are you allergic to any of the following

- Aspirin Yes No
Codeine Yes No
Dental
Anesthetics Yes No
Latex Yes No
Metals Yes No
Penicillin Yes No
Tetracycline Yes No

CERTIFICATION: I certify that the answers given are correct to the best of my knowledge.

Signature

Date

FARMINGTON VILLAGE DENTAL ASSOCIATES, LLC ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

{Please Print Name}

{Signature}

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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FARMINGTON VILLAGE DENTAL ASSOCIATES, LLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET 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 Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (MM/DD/YR), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH 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 Authorization: In addition to our use of your health information for treatment, payment 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 this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. 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 agree that we may do so.

Persons 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 disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use 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.

Required by Law: We may use or disclose your health information when we are required to do so by law.

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, or 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 or safety or the health or safety of others.

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

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

PATIENT RIGHTS

Access: 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 Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.____ for each page, \$____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. 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 this Notice 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, but not before April 14, 2003. 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 alternative means or to alternative locations. **{You must make your request 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 should be amended.) We may deny your request under certain circumstances.

Electronic Notice: 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 this Notice. 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 Officer: Dr. Monique Nadeau

Telephone: 860-676-2288 Fax: 860-676-2292

E-mail:

Address: 320 Main Street, Farmington, CT 06032

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