Patient Information:

Patient: ______________________________ Today's Date: _DD_/_MM_/_YYYY_

I prefer to be called: Mr. Mrs. Miss Nickname: ______________________________

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

Address: ______________________ City: ____________ State: ________ Zip: ________

Phone: ______________ Work: ______________ Cell: ______________

May we text you? Yes No E-Mail: ______________________________

Birth date: DD / MM / YYYY Patient Social Security #: ______________

How did you hear about our office? Patient: ____________ Internet Search Mailer Website Other

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 we last saw you? Yes No

Primary Insurance:

Insurance Co. Name: ______________

Insurance Co. Phone: ______________

Plan ID #: ______________

Group #: ______________

Policy Holders Name: ______________

DOB: DD / MM / YYYY Social: ______________

Relationship to Patient: ______________

Policy Holders Employer: ______________

Secondary Insurance:

Insurance Co. Name: ______________

Insurance Co. Phone: ______________

Plan ID #: ______________

Group #: ______________

Policy Holders Name: ______________

DOB: DD / MM / YYYY Social: ______________

Relationship to Patient: ______________

Policy Holders Employer: ______________

Our office would like to have your permission to use your photos for articles, advertisements, office brochures and educational purposes. Please sign this agreement, which will give us your permission to use pictures of you and your smile.

Signature: ______________________ **Date:** DD / MM / YYYY

Physicians Name: ___________________________

Physicians Telephone: _______________________

Are you currently under the care of a physician?
If yes please explain: ________________________
____

Are you currently taking any prescriptions, over the counter, herbs, supplements or recreational drugs?
If yes please explain: ________________________
____

Do you smoke or use any tobacco in any form? ______
Are you taking birth control pills? _________________
Are you pregnant? ____________________________
Are you nursing? _____________________________

Do you require antibiotic before dental treatment? If yes please explain why: ____________________________

Please provide us with your Pharmacy and the telephone number for our staff to call in prescription:
____

Have you been hospitalized or had a serious illness within the past 5 year? If yes please explain:
____

Please circle any of the following allergies or adverse reaction:

Penicillin	Aspirin	Iodine
Tetracycline	Valium	Codeine
Erythromycin	Barbiturates	Latex
Household Bleach	Advil/Motrin	Sulfa
Local Anesthetics	Other: _________________	

Purpose of today's visit: _________________________

Last dental visit: __________ Last cleaning: __________

What was done?_________________________________

How often do you brush? __________ Floss? _________

Do you use a Manual or Electric toothbrush? _________

Please mark all that apply:

Bleeding gums	Loose teeth	Teeth injury
Broken fillings	Jaw pain	

Do you like your smile? __________________________

Are you currently in pain? _________________________

Do you feel nervous about having dental treatment? ____

Have you ever had a bad experience in a dental office?
____

Pleas check if you have any of the following diseases or medical problems:

Y	N		Y	N	
		Abnormal bleeding			Pysc. Care
		Alcohol/Drug abuse			Radiation
		Alzheimer's disease			Scarlet fever
		Anemia			Seizures
		Arthritis			Sinus problem
		Artificial Bones			Thyroid problem
		Asthma			TB
		Blood Transfusion			Tumors
		Bruise easily			Ulcers
		Cancer/Chemotherapy			Venereal disease
		Colitis			Pacemaker
		Diabetic			Mitral Valve Prolapse
		Difficulty breathing			Low blood Pressure
		Emphysema			Liver disease
		Epilepsy			Kidney problems
		Fainting spells			Joint replacement
		Frequent headaches			HIV/AIDS
		Glaucoma			Herpes/Blisters
		Hay fever			Heart murmur
		Heart problems			Hemophilia
		Hepatitis			
		High blood pressure			

We reserve the right to charge for any appointments not cancelled with 48 hours notice. Regardless of insurance, patients are fully responsible for any account balance. Patients are encouraged to ask all dental & medical Questions to ensure the understanding of the time, limitations, potential complications and cost of all treatment. I certify that all the information that I have provided is accurate to the best of my knowledge. I will not hold any member of the dental staff responsible for actions resulting from errors or omissions that I have made in the completion of this form. **HIPPA-**We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you a copy of our offices HIPPA privacy act, our legal duties, and your rights concerning your health information. This notice took effect 4/15/2003 and will remain in effect until we replace it. At that time you will be notified. **Insurance Assignment:** My signature authorizes the release of necessary information needed to process my claim and to pay any benefits to the provider of my service. (Farmington Village Dental, Dr. Monique Nadeau and Dr. Eric Krause)

Signature____Date: _DD / MM / YYYY

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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