

ADVANCED PERIODONTICS

60 Washington Avenue, Suite 207

Hamden, Connecticut 06518

Phone: 203-288-5916

Fax: 203-230-1213

Name _____ Referring Dentist _____

Address _____ City, State _____ Zip _____

Date of Birth: _____ Social Security # _____

Home Phone: _____ Bus. Phone: _____ Cell: _____

Email: _____ Occupation: _____

Contact in Case of Emergency _____ Phone: _____

Physician's Name _____ Phone _____

Date of last physical _____

Are you now or have you recently been under a physician's care _____

For What Reason _____

Check () if you have had any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Tumor/Malignancy |
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Kidney or Bladder Trouble |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Abnormal Heart Condition | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Asthma or Hay Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Frequent Thirst or Urination | <input type="checkbox"/> Drug or Alcohol Addiction |
| <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Immune Deficiency |
| <input type="checkbox"/> Severe Headaches | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Epilepsy/ Seizures | <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack |

Other: _____

Do you smoke tobacco? YES NO If so, how much? _____

Allergies: Local Anesthetics Aspirin Antibiotics _____
 Sleeping Pills Codeine Metals _____
 Latex Iodine Foods _____

List ALL medications you are currently taking, if any _____

Have you ever taken antibiotics before dental procedures? YES NO

Women only: Are you pregnant? _____ How many months? _____ Are you breast feeding? _____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge.

Signature _____ Date _____

HEALTH INFORMATION PRIVACY POLICIES & PROCEDURES

Recently, the federal government put in place national standards to protect your right to privacy with regard to healthcare information. We take our responsibility to safeguard your healthcare information and inform you of your rights very seriously. In order to make your rights understandable we have developed a readable summary explanation of your rights. You will be asked to sign a form acknowledging having received this information.

I. How we may use your Protected Health Information (PHI).

A. Treatment - In order to provide you with appropriate treatment, we may share information with referring dentists or medical personnel involved in your care. Some information such as HIV status, drug and alcohol dependence and mental health status is entitled to special restrictions related to its use and disclosure.

B. Payment - Treatment rendered may be shared with insurance companies, third party payees and family members who are taking responsibility for payment.

C. Appointment Reminders; Explanation of Insurance Benefits: - We may mail this information to your address of record; we may call your home or office and relate this message directly or leave it on an answering machine or with the individual who answers the phone or we may e-mail or fax this information.

D. Workers Compensation Claims

E. Public Health Risks

F. Law Enforcement Agencies/Lawsuits when provided with proper authorization.

II. Your Rights Regarding your PHI

A. Right to inspect and copy dental records

B. Right to request an addendum to your dental records if you believe they are incorrect

C. Right to an accounting of disclosures of medical information for purposes other than treatment or payment once (over a 12 month period).

D. Right to request restrictions on medical information we disclose about you.

E. You have the right to request that we communicate with you about dental matters and appointments in a certain way or certain location and we will accommodate all reasonable requests.

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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PATIENT BILLING & DENTAL INSURANCE INFORMATION: DATE _____

PATIENT'S NAME _____ SS# _____

ADDRESS _____ DATE OF BIRTH _____

CITY, STATE _____ ZIP CODE _____

HOME PH _____ WK PH _____ CELL PH _____

REFERRING DENTIST _____

NAME OF PERSON TO RECEIVE BILL: _____

ADDRESS: _____

PHONE NUMBER _____ **SS#** _____

PRIMARY DENTAL INSURANCE COMPANY
NAME OF POLICY HOLDER _____

POLICY, ID, OR SUBSCRIBER # _____ **GROUP #** _____

NAME OF INS COMPANY _____

ADDRESS TO SEND CLAIMS _____

CITY, STATE _____ **ZIP CODE** _____

POLICY HOLDER'S DATE OF BIRTH _____ **SS#** _____

NAME OF EMPLOYER _____

EMPLOYER'S ADDRESS _____

CITY, STATE _____ **ZIP CODE** _____

SECONDARY DENTAL INSURANCE COMPANY
NAME OF POLICY HOLDER _____

POLICY # _____ **GROUP#** _____ **GROUP NAME** _____

NAME OF COMPANY _____

ADDRESS TO SEND CLAIMS _____

CITY, STATE _____ **ZIP CODE** _____

NAME OF EMPLOYER _____

EMPLOYER'S ADDRESS _____

PATIENT'S RELATIONSHIP TO POLICY HOLDER _____

POLICY HOLDER'S DATE OF BIRTH _____ **SS#** _____

I UNDERSTAND THAT CERTAIN CHARGES MAY NOT BE COVERED BY MY INSURANCE AND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED.

_____ **DATE** _____

I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE PAYMENT OF BENEFITS TO THE PHYSICIAN OR SUPPLIER FOR SERVICES RENDERED.

_____ **DATE** _____