### DENTAL HISTORY

1. Is this the child's first visit to a dentist? YES NO
2. If not, how long since the last visit to the dentist? 
3. When was the last time the teeth were cleaned? 
4. Does child eat between meals? YES NO
5. Does child eat sweets, such as candy, soda pop, chewing gum? YES NO
6. Does child eat well balanced meals? YES NO
7. Does child brush teeth upon arising?
   - When going to bed? YES NO
   - Right after eating meals? YES NO
   - After eating any food? YES NO
8. Do you live in an area without fluoridated water? YES NO
9. Have teeth been treated with fluorides? YES NO
10. Have any cavities been noted in the past? YES NO
11. Were any teeth (baby or permanent) removed by extraction? YES NO
12. Was it suggested that the space be maintained? YES NO
13. Was appliance placed? YES NO
14. Have there been any injuries to teeth, such as falls, blows, chips, etc.? YES NO
15. If so, describe 
16. Has child had any unfavorable dental experiences? YES NO
17. How many children in your family? 
18. Has anyone in the family, including parents, had orthodontics? YES NO
19. Has child ever received a local anesthetic or any form of anesthetic? YES NO
20. Has child ever had occlusal sealants? YES NO

### MEDICAL HISTORY

1. Is child in good health? YES NO
2. Is child under care of physician? YES NO
   - If yes, since when _Why_ 
3. Name of physician 
4. Is child receiving any medication? YES NO
   - When _Why_ 
5. Has the child had any serious illness? YES NO
   - When _Why_ 
6. Is the child allergic to penicillin, antibiotics or other drugs? YES NO
7. Does the child have any other allergies? YES NO
8. Has child had surgery? YES NO
9. Is surgery contemplated? YES NO
10. Is child subject to profuse bleeding? YES NO
11. Is child subject to nervous disorders?
    - Fainting? YES NO
    - Dizziness? YES NO
12. Has child had history of (Circle appropriate responses.) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, toothache, ear infection. 

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PARENT’S/GUARDIAN’S SIGNATURE __________________________ DATE __________

DENTIST’S SIGNATURE __________________________ DATE __________

MED. ALERT

CHILD DENTAL MEDICAL HISTORY

Form No. 131CDM
PATIENT'S NAME
Last
First
Initial

IF CHILD:
PARENT'S NAME
Last
First
Initial

HOW DO YOU WISH TO BE ADDRESSED
Single [□] Married [□] Separated [□] Divorced [□] Widowed [□] Minor [□]

RESIDENCE - STREET
CITY [ ] STATE [ ] ZIP [ ]

BUSINESS ADDRESS
TELEPHONE: RES. [ ] BUS. [ ]

PATIENT/PARENT EMPLOYED BY
PRESENT POSITION [ ] HOW LONG HELD [ ]

SPouse/Parent NAME
SPouse EMPLOYED BY
PRESENT POSITION [ ] HOW LONG HELD [ ]

WHO IS RESPONSIBLE FOR THIS ACCOUNT

DRIVERS LICENSE NO.

METHOD OF PAYMENT: Insurance [□] Credit Card [□] Cash [□]

PURPOSE OF CALL

OTHER FAMILY MEMBERS IN THIS PRACTICE

WHOM MAY WE THANK FOR THIS REFERRAL

PATIENT/PARENT SOCIAL SECURITY NO.

SPouse/Parent SOCIAL SECURITY NO.

SOMEONE TO NOTIFY IN CASE OF EMERGENCY NOT LIVING WITH YOU

DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE NAME

EMPLOYEE DATE OF BIRTH

EMPLOYER [ ] # YRS.

NAME OF INSURANCE CO.

ADDRESS

TELEPHONE

PROGRAM OR POLICY #

UNION LOCAL OR GROUP

SOCIAL SECURITY NO.

DENTAL INSURANCE 2ND COVERAGE

EMPLOYEE NAME

EMPLOYEE DATE OF BIRTH

EMPLOYER [ ] # YRS.

NAME OF INSURANCE CO.

ADDRESS

TELEPHONE

PROGRAM OR POLICY #

UNION LOCAL OR GROUP

SOCIAL SECURITY NO.

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE

DATE

REGISTRATION
<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you under a physician's care?</td>
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<td>Since when?</td>
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<tr>
<td>Why</td>
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<td>Are you taking any medication or substances?</td>
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<tr>
<td>Do you routinely take health related substances?</td>
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<tr>
<td>Are you allergic to any medications or substances?</td>
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<tr>
<td>Do you have any other allergies?</td>
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<tr>
<td>Do you have any problem with penicillin, antibiotics, anesthetics or other medications?</td>
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<tr>
<td>Are you sensitive to any metals or latex?</td>
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<tr>
<td>Are you pregnant or suspect you may be?</td>
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<tr>
<td>Do you use any birth control medications?</td>
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<tr>
<td>Have you ever been treated for or been told you might have heart disease?</td>
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<td>Have you had a pacemaker or an artificial heart valve implant?</td>
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<td>Have you ever had rheumatic fever?</td>
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<td>Have you ever been treated for bacterial endocarditis?</td>
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<td>Do you have high or low blood pressure?</td>
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<tr>
<td>Have you ever had a serious illness or major surgery?</td>
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<tr>
<td>If so, explain</td>
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<tr>
<td>Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition?</td>
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<td>Do you have inflammatory diseases, such as arthritis or rheumatism?</td>
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<td>Do you have any artificial joints/prosthesis?</td>
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<td>Do you have any blood disorders, such as anemia, leukemia, etc?</td>
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<td>Have you ever bled excessively after being cut or injured?</td>
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<td>Do you have any stomach problems?</td>
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<td>Do you have any kidney problems?</td>
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<tr>
<td>Do you have any liver problems?</td>
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<tr>
<td>Are you diabetic?</td>
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<tr>
<td>Do you have asthma?</td>
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<td>Do you have epilepsy or seizure disorders?</td>
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<td>Do you or have you had venereal disease?</td>
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<td>Have you tested HIV positive?</td>
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<td>Do you have AIDS?</td>
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<td>Have you had or do you test positive for hepatitis?</td>
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<td>Do you or have you had T.B.?</td>
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<tr>
<td>Do you smoke, chew, use snuff or any other forms of tobacco?</td>
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<tr>
<td>Do you consume alcoholic beverages?</td>
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<td>Do you habitually use controlled substances?</td>
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<tr>
<td>Have you had psychiatric treatment?</td>
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<tr>
<td>Do you have any disease, condition, or problem not listed? If so, explain</td>
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<tr>
<td>Is there anything else we should know about your health that we have not covered in this form?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Would you like to speak to the Doctor privately about any problem?</td>
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</tr>
</tbody>
</table>

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE

DENTIST'S SIGNATURE

ANEST.

MEDICAL HISTORY
JOHN A. GANNATTI, D.D.S.
DONALD J. ANNICELLE, D.D.S.
PAMELA A. MOORE, D.M.D.
836 FARMINGTON AVE, SUITE 120
WEST HARTFORD, CT 06119

HIPAA PRIVACY FORM

Your name and signature on this sheet indicates that you have received a copy of Notices of Privacy Practices on the date indicated. If you have any questions regarding the information in this Privacy Notice, please do not hesitate to contact a representative or administrator of this office as indicated on your notice.

PATIENT NAME (PRINTED): ________________________________

IF PATIENT REPRESENTATIVE, NAME: ____________________

IF PATIENT REPRESENTATIVE, RELATIONSHIP TO PATIENT:
________________________________________________________

SIGNATURE: ____________________________________________

DATE NOTICE RECEIVED: _________________________________
Notice of Privacy Practices

**Purpose:** This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. (Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.)

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgment of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.
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 on April 1, 2003, 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 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 compliance 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 practically 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 $0.75 per page, $25.00 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: Inna Masco or Sheryl Cusanno

Telephone: 880-523-4239 Fax

E-mail: 

Address: 836 Farmington Ave Suite 120 West Hartford, Ct. 06119

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