Date _____

Patient Information

Name _____ Home Phone _____
Social Security # _____ Cell Phone _____
Birth Date _____ Email Address _____
Which method do you prefer for appointment reminders? ☐ Email ☐ Cell Phone/Text ☐ Home Phone
May we email you our monthly electronic newsletter: ☐ Yes ☐ No

Home Address _____
City _____ State/Zip _____
Employed By _____ Work Phone/Ext _____
Address of Employment _____
Name of Spouse _____ Spouse Birth Date _____
Spouse's Social Security _____ Spouse Employed By _____
Who may we thank for referring you? _____
If other than patient please sign here _____
Emergency Contact Name & Phone Number _____

Payment Method

I hereby choose one of the following methods of payment for my dental care and the care of any immediate family members.

☐ I have no dental insurance.

_____ I elect to pay cash ___, check ___, or credit card at all visits as treatment progresses. On extensive treatment, financial arrangements can be established.

☐ I have dental insurance.

_____ I agree to pay any out of pocket expenses and deductible at the time of service.
_____ On extensive treatment, I elect to participate in financial arrangements coordinating insurance coverage and out-of-pocket expenses.
_____ I elect to coordinate insurance money as pre-authorized.

I HEREBY AGREE TO PAY ALL FINANCE CHARGES OF 12% ANNUALLY ON ANY BALANCES OVER 60 DAYS.

Insurance Information

I hereby authorize The Dental Team to bill my insurance company for treatment provided.
Your Dental Insurance Company _____ Tel # _____
Insurance Address _____
Group/or Employer _____Group # _____ID# _____
Spouse's Dental Insurance Company _____ Tel # _____
Insurance Address _____
Group/ or Employer _____Group # _____ID# _____

Payment Agreement

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY. I GUARANTEE PAYMENT OF ALL CHARGES INCURRED FOR THE ACCOUNT OF THE BELOW PATIENT. I AGREE TO PAY FINANCE CHARGES OF 12% ANNUALLY ON ANY BALANCE OVER 60 DAYS. I FURTHER AGREE TO REIMBURSE THE DENTAL TEAM THE FEES OF ANY COLLECTION AGENCY. THESE FEES MAY BE BASED ON A PERCENTAGE OF A MAXIMUM OF 33% OF THE DEBT, ALL COSTS, AND EXPENSES, INCLUDING REASONABLE ATTORNEY FEES THAT THE DENTAL TEAM INCUR IN SUCH COLLECTION EFFORTS.

_____ _____
Patient or Authorized Guardian Signature Date

Authorization to Release Information

I HEREBY AUTHORIZE THE DENTAL TEAM TO PROVIDE ANY INSURANCE COMPANY(S), CLAIM ADMINISTRATOR(S), AND CONSULTING HEALTH CARE PROFESSIONALS, INFORMATION CONCERNING HEALTH CARE, ADVICE, TREATMENT, OR SUPPLIES PROVIDED. THIS INFORMATION WILL BE USED EXCLUSIVELY FOR THE PURPOSE OF EVALUATING AND ADMINISTERING CLAIMS FOR BENEFITS.

I HEREBY AGREE TO PAY FINANCE CHARGES OF 12% ANNUALLY ON ANY BALANCE OVER 60 DAYS. I HEREBY AUTHORIZE THE DENTAL TEAM TO RUN A CREDIT REPORT IF NECESSARY.

_____ _____
Patient or Authorized Guardian Signature Date

Date _____

New Patient Dental History

How can we help you? _____

When was your last dental visit? _____ Were X-Rays taken? ☐ Yes ☐ No Date _____

Was there any dental treatment recommended that has not been completed? ☐ Yes ☐ No

If yes, please explain _____

How often did you visit the Dentist in the past? _____

Previous Dentist name, address, telephone number _____

How often do you brush your teeth? _____ Floss your teeth? _____

Are you in any dental discomfort now? _____

Have you had any prior dental experiences that have been unpleasant? ☐ Yes ☐ No

If yes, please explain _____

Do your gums bleed while brushing or flossing?	☐ Yes ☐ No	Do you have frequent headaches?	☐ Yes ☐ No
Are your teeth sensitive to hot or cold liquids/foods or sweets?	☐ Yes ☐ No	Are you having any problems with snoring?	☐ Yes ☐ No
Are you aware of any sores or lumps in or near your mouth?	☐ Yes ☐ No	Have you ever had periodontal treatment (gums)?	☐ Yes ☐ No
Do you feel pain in your teeth?	☐ Yes ☐ No	Have any of your teeth become loose?	☐ Yes ☐ No
Have you had any head, neck or jaw injuries?	☐ Yes ☐ No	Does food tend to become caught between your teeth?	☐ Yes ☐ No
Do you clench or grind your teeth?	☐ Yes ☐ No	Have you had orthodontic treatment/braces?	☐ Yes ☐ No
Have you ever experienced any of the following problems in you jaw? ☐ Clicking or popping while chewing? ☐ Pain (Joint, ear or side of face)? ☐ Difficulty in chewing? ☐ Difficulty in opening or closing? ☐ Avoid eating on one side?		Have you ever had prolonged bleeding	☐ Yes ☐ No
		Do you wear dentures or partials? If yes, date of placement _____	☐ Yes ☐ No
		Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐ Yes ☐ No
		Do you like your smile?	☐ Yes ☐ No

If you could change anything about your SMILE, what would that be? _____

Would you like to whiten/bleach your teeth? ☐ Yes ☐ No

Authorization and Release

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND TO THE BEST OF MY KNOWLEDGE THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS IF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYERS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OD ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS. THERE WILL BE A FINANCE CHARGE ON ALL BILLS MORE THAN 60 DAYS OLD.

_____ _____

Patient or Authorized Guardian Signature Date

DOCTOR'S COMMENTS _____

_____

_____ _____

Doctor Signature Date

PATIENT NAME _____ **DATE** _____

Patient Information — MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ❍ Yes ❍ No Physician's Name _____ If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ❍ Yes ❍ No If yes, please explain: _____

Have you ever had a serious head or neck or jaw injury? ❍ Yes ❍ No If yes, please explain: _____

Are you taking any medications, pills, or drugs, or natural or herbal supplements? ❍ Yes ❍ No If yes, please explain: _____

Do you take, or have you taken, (Fen-Phen) or (Redux) or Diet Pills? ❍ Yes ❍ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ❍ Yes ❍ No _____

Are you on a special diet (gluten free, lactose free, etc.) ? ❍ Yes ❍ No _____

Do you use tobacco products? ❍ Yes ❍ No _____

Do you take blood thinners (Coumadin, Aspirin, Plavix, Pradaxa, Fish Oil, Vitamin E, Ginko Biloba)? ❍ Yes ❍ No _____

Do you have a prosthetic joint/implant? ❍ Yes ❍ No _____

Have you had open heart surgery, heart valave replacement or vascular graft ? ❍ Yes ❍ No _____

Have you been told or do you need to pre-medicate with antibiotics prior to dental procedures? ❍ Yes ❍ No _____

Have you ever had any unusual or serious reactions to epinephrine or local anesthetics? ❍ Yes ❍ No _____

Women: Are you

Pregnant/Trying to get pregnant? ❍ Yes ❍ No Taking Oral Contraceptives? ❍ Yes ❍ No Nursing? ❍ Yes ❍ No

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin/Amoxicillin ❑ Codeine ❑ Acrylic ❑ Local Anesthetics ❑ Metal ❑ Latex ❑ Sulfa Drugs ❑ Sulfites ❑ Tetracycline

Do you have, or have you had, any of the following?

Acid Reflux/GERD ❍ Yes ❍ No	Cortisone Medicine ❍ Yes ❍ No	Hemophilia ❍ Yes ❍ No	Psychiatric Care ❍ Yes ❍ No
AIDS/HIV Positive ❍ Yes ❍ No	Delayed Healing ❍ Yes ❍ No	Hepatitis A ❍ Yes ❍ No	Radiation Treatments ❍ Yes ❍ No
Alzheimer's Disease ❍ Yes ❍ No	Developmental Diseases ❍ Yes ❍ No	Hepatitis B or C ❍ Yes ❍ No	Recent Weight Loss ❍ Yes ❍ No
Anaphylaxis ❍ Yes ❍ No	Diabetes ❍ Yes ❍ No	Herpes ❍ Yes ❍ No	Renal Dialysis ❍ Yes ❍ No
Anemia ❍ Yes ❍ No	Drug Addiction ❍ Yes ❍ No	High Blood Pressure ❍ Yes ❍ No	Rheumatic Fever ❍ Yes ❍ No
Angina ❍ Yes ❍ No	Easily Winded ❍ Yes ❍ No	High Cholesterol ❍ Yes ❍ No	Rheumatism ❍ Yes ❍ No
Arthritis/Gout ❍ Yes ❍ No	Emphysema ❍ Yes ❍ No	Hives or Rash ❍ Yes ❍ No	Scarlet Fever ❍ Yes ❍ No
Artificial Heart Valve ❍ Yes ❍ No	Epilepsy or Seizures ❍ Yes ❍ No	Hypoglycemia ❍ Yes ❍ No	Shingles ❍ Yes ❍ No
Artificial Joint ❍ Yes ❍ No	Excessive Bleeding ❍ Yes ❍ No	Irregular Heartbeat ❍ Yes ❍ No	Sickle Cell Disease ❍ Yes ❍ No
Asthma ❍ Yes ❍ No	Excessive Thirst ❍ Yes ❍ No	Kidney Problems ❍ Yes ❍ No	Sinus Trouble ❍ Yes ❍ No
Blood Disease ❍ Yes ❍ No	Fainting Spells/Dizziness ❍ Yes ❍ No	Leukemia ❍ Yes ❍ No	Snore/Sleep Apnea ❍ Yes ❍ No
Blood Transfusion ❍ Yes ❍ No	Frequent Cough ❍ Yes ❍ No	Liver Disease ❍ Yes ❍ No	Spina Bifida ❍ Yes ❍ No
Breathing Problem ❍ Yes ❍ No	Frequent Diarrhea ❍ Yes ❍ No	Low Blood Pressure ❍ Yes ❍ No	Stomach/Intestinal Disease ❍ Yes ❍ No
Bruise Easily ❍ Yes ❍ No	Frequent Headaches ❍ Yes ❍ No	Lung Disease ❍ Yes ❍ No	Stroke ❍ Yes ❍ No
Cancer ❍ Yes ❍ No	Gallbladder Trouble ❍ Yes ❍ No	Measles or Mumps ❍ Yes ❍ No	Swelling of limbs ❍ Yes ❍ No
Canker Sores ❍ Yes ❍ No	Genital Herpes ❍ Yes ❍ No	Mitral Valve Prolapse ❍ Yes ❍ No	Thyroid Disease ❍ Yes ❍ No
Chemotherapy ❍ Yes ❍ No	Glaucoma ❍ Yes ❍ No	Mononucleosis ❍ Yes ❍ No	Tonsillitis ❍ Yes ❍ No
Chest Pains ❍ Yes ❍ No	Hay Fever ❍ Yes ❍ No	Neurological Diseases ❍ Yes ❍ No	Tuberculosis ❍ Yes ❍ No
Crohns or Celiac Disease ❍ Yes ❍ No	Heart Attack/Failure ❍ Yes ❍ No	Osteoporosis ❍ Yes ❍ No	Tumors or Growths ❍ Yes ❍ No
Cold Sores/Fever Blisters ❍ Yes ❍ No	Heart Murmur ❍ Yes ❍ No	Pain in Jaw Joints ❍ Yes ❍ No	Venereal Disease ❍ Yes ❍ No
Congenital Heart Disorder ❍ Yes ❍ No	Heart Pacemaker ❍ Yes ❍ No	Parathyroid Disease ❍ Yes ❍ No	Yellow Jaundice ❍ Yes ❍ No
Convulsions ❍ Yes ❍ No	Heart Trouble/Disease ❍ Yes ❍ No	Pneumonia ❍ Yes ❍ No	

Have you ever had any serious illness not listed above? ❍ Yes ❍ No _____

Comments:

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's health). It is my responsibility to inform the dental office on any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Annamarie Faubel

Telephone: 303-775-1771 Fax: 203-775-1967

E-mail: TheDentalTeamCT@gmail.com

Address: 109 Federal Road, Brookfield CT 06804

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.