Personal Information Form

Dental Care of Stamford
1500 Summer Street
Stamford, CT 06905
Phone: (203) 324-6171

Date: _____

Patient's First Name: _____ Last Name: _____ How do you prefer to be addressed: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Age: _____ Birth Date: ___/___/_____ ☐ Single ☐ Married ☐ Widow ☐ Separated ☐ Divorced SS#: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email Address: _____

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

If Student, name of School/College: ☐ PT ☐ FT _____ City: _____ State: _____ Zip: _____

How did you first hear about our office: _____

Do we have your permission to send you occasional correspondence on informative dental topics as well as reminders of your appointments via email? You may opt out at any time. ☐ Yes ☐ No

If the person responsible for this payment is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section entitled "Insurance Information"

Name of Responsible Party: _____ Relationship to Patient: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Age: _____ Birth Date: ___/___/_____ ☐ Single ☐ Married ☐ Widow ☐ Separated ☐ Divorced SS#: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email Address: _____

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Insurance Information

Policy Holder's Name: _____ Relationship to Patient: _____ SS#: _____ DOB: ___/___/_____

Name of Employer: _____ Employer Address: _____ State: _____

Insurance Co.: _____ Group #: _____ Address: _____ ID #: _____

Secondary Insurance Information

Policy Holder's Name: _____ Relationship to Patient: _____ SS#: _____ DOB: ___/___/_____

Name of Employer: _____ Employer Address: _____ State: _____

Insurance Co.: _____ Group #: _____ Address: _____ ID #: _____

I certify that all of the information (including medical, personal, and insurance records) is true and complete. I understand that Dental Care of Stamford will assist me in filing my claims, but the insurance coverage I have for dental services can vary and will depend on my insurance plan. I understand that I am responsible for all fees and services. Since our doctors often provide continuing education to other doctors, I give my permission to use my photos for educational purposes. I have read and agree to your HIPAA Notice of Privacy Practices on page 3.

If the patient is a minor, as the responsible party I give permission, in my absence, to provide examinations, dental cleanings and necessary x-rays as part of routine care for this patient.

We require 48 hours advance notice if you are unable to keep your appointment. Failure to do so could result in a charge. Finance charges will be assessed on any account that is 60 days or more past due at the rate of 1.5% per month. Thank you for your cooperation.

Signature of Patient (Responsible Party if a minor): Please sign the form when you come into our office

Family Member Information

Please list the names of your spouse and children	Is person a patient Yes | No	Sex M | F	Age	Date of Birth (mm/dd/yyyy)
	☐ ☐	☐ ☐		
	☐ ☐	☐ ☐		
	☐ ☐	☐ ☐		

Please list the names of your spouse and children	Is person a patient Yes | No	Sex M | F	Age	Date of Birth (mm/dd/yyyy)
	☐ ☐	☐ ☐		
	☐ ☐	☐ ☐		
	☐ ☐	☐ ☐		

(Please continue to the next page)

Medical and Dental Health History Form

Medical Doctor's Name:_____ Doctor's Phone #:_____ Date of last completed physical:_____

Doctor's Address:_____ City:_____ State:_____ Zip:_____

Are you taking any medication, vitamins or supplements? ☐ Yes ☐ No

If yes, please list:_____

For what purpose?_____

Are you pregnant? ☐ Yes ☐ No If yes, how many months:_____

Rate your medical health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you allergic or react to: ☐ Penicillin ☐ Codeine ☐ Local injected Anesthetic ☐ Latex ☐ Other _____

Do you have: ☐ a heart murmur ☐ a heart condition ☐ diabetes ☐ joint replacements ☐ implants

Have you ever been told that because of this that you need to take antibiotics prior to dental cleanings or other treatment? ☐ Yes ☐ No

Do you have or have you ever had any of the following

Arthritis	☐ Yes ☐ No	Herpes or HPV	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No
Radiation treatments	☐ Yes ☐ No	Asthma or hay fever	☐ Yes ☐ No	Low blood pressure	☐ Yes ☐ No
Malignancies	☐ Yes ☐ No	Persistent cough	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Aids, HIV positive	☐ Yes ☐ No	Jaundice/Hepatitis	☐ Yes ☐ No
Ulcers	☐ Yes ☐ No	Prolonged Bleeding	☐ Yes ☐ No	Narrow Angle Glaucoma	☐ Yes ☐ No
Sinus trouble	☐ Yes ☐ No	Psychiatric care, nervous problems	☐ Yes ☐ No	Heart Attack/Stroke	☐ Yes ☐ No
				Osteoporosis	☐ Yes ☐ No

Please describe any current treatment, impending operation, or any other medical or dental condition that you have.

_____

General Dental Health and Concerns

What's most important to you about your teeth?_____

How would you rate your dental health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What is the main barrier to your dental health being better? ☐ Fear ☐ Time ☐ Costs ☐ Other _____

Is keeping your teeth important to you? ☐ Yes ☐ No If yes, why?_____

Does having dental work make you feel anxious, nervous, or fearful? ☐ Yes ☐ No

How can we help you with any issues?_____

Do you have any: ☐ Discomfort in teeth or mouth ☐ Bleeding gums ☐ Bad breath ☐ Food traps around teeth

Which issues are most important to you in making dental health decisions:

- ☐ Convenient appointment times
- ☐ Comfort aids such as, headphones, TV's, Nitrous Oxide
- ☐ Detailed treatment explanations and a chance to ask questions
- ☐ Dental Specialist in site
- ☐ Dealing with anxiety associated with dental care
- ☐ Quality care and materials
- ☐ Using your dental insurance
- ☐ Availability of sedation for dental work

Dental Appearance

How would you rate the appearance of your smile from 1 - 10 ?_____

If you could make any changes about your dental appearance what would be important to you:

- ☐ Whiten Teeth
- ☐ Create a more youthful looking smile
- ☐ Replacing missing teeth
- ☐ Close spaces between teeth
- ☐ Replace discolored or old looking crowns
- ☐ Repair worn, chipped or broken teeth
- ☐ Remove silver fillings for health reasons
- ☐ Straighten teeth with braces or Invisalign

Head, Neck or Facial Pain

Do you ever get:

☐ Stress headaches ☐ Migraines ☐ Ear pain ☐ T M Joint pain ☐ Sensitive teeth ☐ Clicking in Jaw Joints ☐ Hard to chew or pain with chewing

Do you ever need to take any drugs or medicines to relieve the pain?_____

Have you consulted with any doctors about these issues?_____

After completing the forms, please print and bring the forms to our office

Print Form

Dental Care of Stamford/Dental Care Kids
HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL/DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REA AND REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical, dental or mental health condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills to support the operation of the dentist/physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party (such as Family members, etc.). We will also disclose to a family member, spouse, adult children, and information as necessary for your overall dental care. By signing this document, you give permission to share your dental health information with any family member, friend or other persons to the extend necessary to help with your healthcare and/or with payment for your healthcare.
For example: we would disclose your protected health information, as necessary, to a home health agency that provides care to you. An another example would be when we would need to share your records of information to a specialist or a physician to whom you have been referred to, to ensure that the physician or specialist has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used as needed to obtain payment for your health/dental care services, including from your family members or friends. For example: obtaining approval for a dental procedure from an insurance carrier that may require that your relevant protected health information be disclosed to the insurance plan to obtain approval for the procedure.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review, activities, training of medical/dental students, licensing, and conducting or arranging for other business activities. For example: we may disclose your protected health information to dental/hygiene students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may use or disclose your protected health information as necessary to contact you to remind you of your appointment via mail or by phone.

We may use or disclose your protected health information in the following situations without your authorization: These situations include: as Required by Law, Public Health issues as required by Law, Communicable Diseases, Health Oversight Abuse or Neglect, Food and Drug Administration requirements, Legal Proceeding, Law Enforcement, Coroners, Funeral Directors, Organ Donation services, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Your rights:
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply in writing.

Your physician/dentist is not required to agree to a restriction that you may request. If physician/dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by an alternative means or at an alternative location.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i. e. electronically.

You may have the right to have your physician/dentist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complain. We will not retaliate against you for filing a complaint.

This notice was published and was placed in effect on **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number (203-324-6171).