WAYPOINT PERIODONTICS
Lavanya Rajendran, DMD, MDSc

2 Trap Falls Road, Suite 202
Shelton, CT 06484
203-446-3890 | fax 203-446-3889

PATIENT REGISTRATION & MEDICAL HISTORY

Please complete all sections as accurately as possible. This information is kept strictly confidential.

PATIENT INFORMATION

Last Name | First Name | Middle Initial

Date of Birth (MM/DD/YYYY) | Sex | Preferred Name / Pronouns

Home Address

City | State | ZIP Code

Home / Cell Phone | Work Phone | Email Address

Preferred Contact Method (Phone / Text / Email) | SSN (last 4 digits, optional)

Employer | Occupation

EMERGENCY CONTACT

Emergency Contact Name | Relationship to Patient

Emergency Contact Phone

REFERRAL & DENTAL INFORMATION

Referring Dentist / Physician | Referring Practice Phone

General Dentist (if different) | Date of Last Dental Cleaning / Exam

Reason for Today's Visit

DENTAL INSURANCE (IF APPLICABLE)

Insurance Company | Subscriber Name & Date of Birth

Subscriber ID / Member Number | Group Number | Relationship to Subscriber

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PHYSICIAN INFORMATION

Primary Care Physician

Physician Phone

Date of Last Physical Exam

Currently under a physician's care? For what?

Preferred Pharmacy

MEDICAL HISTORY

Are you currently in good health? ☐ Yes ☐ No

Any change in your general health within the past year? ☐ Yes ☐ No

Please check any conditions you have or have had:

- ☐ AIDS/HIV Positive
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pain
- ☐ Cold Sores/Fever Blisters
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting/Dizziness
- ☐ Glaucoma
- ☐ Head/Neck Injuries
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Hemophilia
- ☐ Hepatitis A/B/C
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers

Other medical conditions not listed above:

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Current Medications (include dosage), Vitamins & Supplements:

Allergies (medications, latex, foods, other):

Ever taken bisphosphonates (e.g. Fosamax, Boniva, Prolia, Xgeva)? ☐ Yes ☐ No

If yes, medication & duration:

Require antibiotic pre-medication prior to dental treatment? ☐ Yes ☐ No

Have you had any surgeries? If yes, please list (type & date):

Tobacco use: ☐ Never ☐ Former ☐ Current

Alcohol use: ☐ Never ☐ Occasionally ☐ Regularly

Recreational or other drug use: ☐ Yes ☐ No

For female patients — Pregnant: ☐ Yes ☐ No ☐ N/A

Nursing: ☐ Yes ☐ No Taking oral contraceptives: ☐ Yes ☐ No

CONSENT & ACKNOWLEDGMENT

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 health. It is my responsibility to inform this office of any changes in my medical history. I authorize the doctor and staff to release any information, including diagnosis and records of any treatment, for insurance and referral purposes, and I authorize payment of insurance benefits directly to Waypoint Periodontics.

Patient / Guardian Signature

Date

Printed Name

Relationship to Patient (if signing on behalf)

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NOTICE OF PRIVACY PRACTICES

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

Effective Date: August 10, 2026

Our Commitment to Your Privacy

This practice is required by law to maintain the privacy of your protected health information (PHI), to provide you with this notice describing our legal duties and privacy practices, and to follow the terms of the notice currently in effect.

How We May Use and Share Your Health Information

Treatment

We may use and share your health information to provide, coordinate, or manage your dental and periodontal care, including consultation with referring dentists, specialists, or other treating providers.

Payment

We may use and share your health information to bill and collect payment from you, an insurance company, or a third party, including verifying coverage, submitting claims, and obtaining prior authorization.

Healthcare Operations

We may use and share your health information to run our practice, improve your care, and contact you, including for quality assessment, staff training, and appointment reminders.

Other Permitted or Required Uses

We may also use or share your information, generally without requiring your written authorization, in the following situations:

- As required by federal, state, or local law
- For public health activities, such as reporting disease outbreaks
- To a health oversight agency for audits, investigations, or inspections
- In response to a court order, subpoena, or other lawful process
- With law enforcement, if required or permitted by law
- To avert a serious threat to health or safety
- For workers' compensation claims, as authorized by law
- With coroners, medical examiners, or funeral directors, as necessary

For any use or disclosure not described above, we will ask for your written authorization, which you may revoke at any time in writing.

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Your Rights

- Get a copy of your paper or electronic dental and billing records
- Request that we correct your records if you believe they are incorrect or incomplete
- Request confidential communication, such as contacting you at a different phone number or address
- Ask us to limit what we use or share, though we are not required to agree
- Receive a list of certain disclosures we have made of your health information
- Choose someone to act on your behalf, such as a legal guardian or medical power of attorney
- Receive a paper copy of this notice at any time, even if you agreed to receive it electronically
- File a complaint if you feel your privacy rights have been violated, with this practice or with the U.S. Department of Health and Human Services, without fear of retaliation

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information
- We will let you know promptly if a breach occurs that may have compromised your information
- We must follow the duties and privacy practices described in this notice and give you a copy of it
- We will not use or share your information other than as described here unless you provide written authorization, which you may revoke at any time

Changes to This Notice

We reserve the right to change this notice. We may make the revised notice effective for health information we already have as well as any information we receive in the future. The current notice will be available upon request and posted in our office.

Questions or Complaints

If you have questions about this notice or wish to file a complaint, please contact:

Privacy Contact: Dr. Lavanya Rajendran, Privacy Officer — info@waypointperio.com

Phone: 203-446-3890

You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

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COMMUNICATION, PRIVACY (HIPAA), AND PHOTOGRAPHY/MEDIA CONSENT

Patient Name: _____ Date of Birth: _____

Today's Date: _____ Chart / Account #: _____

This form covers three separate consents. Please read each section, initial where indicated, and complete the signature block at the end. You may decline any single section without affecting your eligibility for treatment, except where a specific communication method is required for us to reach you about your care.

1. Communication Consent

From time to time we may need to contact you regarding appointment reminders, treatment recommendations, lab or referral results, billing, or other matters related to your care. Please indicate which methods you authorize us to use and provide your preferred contact information.

Phone call to a landline or mobile number, including messages that may reference appointments or treatment

Text message (SMS) to a mobile number, including appointment reminders and practice notifications

Email to the address provided below

Detailed voicemail/answering machine messages that may include appointment or treatment information

Regular mail to the address on file

Preferred phone number(s): _____

Preferred email address: _____

Text message and data rates from your mobile carrier may apply. You may opt out of text messages at any time by replying STOP, or by notifying our office in writing or by phone. Standard email and SMS are not secure or encrypted; there is a risk that messages could be intercepted or accessed by unauthorized parties in transit. If you prefer not to receive treatment details by email or text, please select phone or mail only above.

If we are unable to reach you directly, may we leave a detailed message (including appointment date/time and general treatment purpose) with another person at the number provided, or must we leave only a general callback request?

Detailed message may be left with another person / on voicemail

General callback request only — no treatment or appointment details

Emergency contact name & relationship: _____

Emergency contact phone number: _____

Patient Initials: _____ *I have reviewed and selected my communication preferences above.*

2. HIPAA Privacy Consent & Acknowledgment

Under the Health Insurance Portability and Accountability Act (HIPAA), you have rights regarding the privacy of your protected health information (PHI). This section confirms your acknowledgment of our privacy practices and your authorization for certain disclosures.

I acknowledge that I have been offered and/or received a copy of this practice's Notice of Privacy Practices, which describes how my health information may be used and disclosed.

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I understand that this practice may use and disclose my PHI without additional authorization for purposes of treatment, payment, and healthcare operations (for example, coordinating care with other providers, submitting insurance claims, and internal quality review).

I authorize this practice to discuss my protected health information, including treatment details, appointment scheduling, and billing, with the following individual(s):

Name & relationship (1): _____

Name & relationship (2): _____

If left blank, no additional individuals are authorized and information will be discussed only with the patient (or legal guardian).

I understand that I have the right to: request restrictions on certain uses and disclosures of my PHI; inspect and obtain a copy of my health records; request corrections to my records; and revoke this authorization in writing at any time, except to the extent the practice has already acted in reliance on it.

Patient Initials: _____ *I acknowledge the above HIPAA privacy terms and authorize disclosures as indicated.*

3. Photography, Video & Digital Imaging Consent

As part of standard clinical documentation, this practice routinely takes intraoral and extraoral photographs, radiographs, and/or video as a part of diagnosis, treatment planning, and your permanent dental record. This clinical documentation is standard of care and is not optional.

I consent to clinical photographs, radiographs, and video as part of my treatment record and for consultation with other treating providers or specialists (required for treatment).

Separately, we may wish to use de-identified or identifiable images for the following purposes. Each is optional and does not affect your treatment:

Professional education, teaching, or case presentations, using de-identified images (no name or identifying information attached)

Marketing materials, our website, or social media, using de-identified images only (no name, face, or other identifying information attached)

This practice does not post identifiable patient photographs (including recognizable facial images) on social media or in marketing materials. If you consent to de-identified marketing use, you may revoke this specific consent in writing at any time; however, we may not be able to remove images that have already been published or shared by third parties prior to your revocation.

Patient Initials: _____ *I have selected my photography/media preferences above and understand that clinical documentation photographs are required for treatment, and that any marketing or social media use will be limited to de-identified images.*

Acknowledgment

By signing below, I confirm that I have read this form, had the opportunity to ask questions, and that my selections above accurately reflect my preferences. I understand I may update or revoke any of these consents in writing at any time, except to the extent this practice has already relied on my prior authorization.

Patient / Legal Guardian Signature

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient (if applicable): _____

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Witness / Staff Signature

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient (if applicable): _____

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FINANCIAL POLICY & PAYMENT AGREEMENT

Patient Name: _____ Date of Birth: _____

Today's Date: _____ Chart / Account #: _____

Thank you for choosing Waypoint Periodontics. We are committed to providing you with the highest quality periodontal care. Please read the following financial policy carefully, as it governs your financial responsibility for treatment received at this practice.

Out-of-Network Status

Waypoint Periodontics is an out-of-network provider with all dental and medical insurance plans. This means we do not have a contracted fee agreement with any insurance carrier, and reimbursement rates and coverage are determined solely by your insurance plan, not by this practice.

Being out-of-network does not mean your insurance won't help cover treatment — many PPO plans provide out-of-network benefits. However, the patient is responsible for the full cost of treatment regardless of how much, if anything, your insurance plan reimburses.

Payment Due at Time of Service

Payment in full is due on the day treatment is rendered. This applies to all services, including consultations, non-surgical treatment, and surgical procedures, unless other arrangements have been discussed and confirmed in advance with our office.

Accepted payment methods: _____

Insurance Submitted as a Courtesy

As a courtesy to our patients, we will prepare and submit a claim to your insurance carrier on your behalf following treatment. Please note:

- Because we are out-of-network, insurance reimbursement is typically sent directly to the patient, not to this practice.
- Any estimate of insurance coverage provided by our office is an estimate only, based on information available at the time, and is not a guarantee of payment.
- The patient is responsible for the full fee for services rendered regardless of the amount, timing, or outcome of any insurance reimbursement, including denials, deductibles, waiting periods, or coverage disputes.
- It remains the patient's responsibility to understand their own out-of-network benefits, including deductibles and reimbursement percentages, and to follow up with their insurance carrier as needed.

Refunds

If an overpayment or credit balance is identified on your account (for example, following insurance reimbursement processed through our office), any refund due will be issued within a reasonable timeframe after the credit is confirmed.

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Minors

For patients under 18, the accompanying parent or legal guardian is responsible for payment at the time of service.

Patient Initials: _____ *I understand that Waypoint Periodontics is out-of-network with my insurance, that payment in full is due on the day of treatment, and that insurance will be submitted only as a courtesy.*

Acknowledgment

By signing below, I acknowledge that I have read and understand this Financial Policy & Payment Agreement, and I agree to be financially responsible for all services rendered to me (or to the patient named above, if I am signing as a parent or legal guardian).

Patient / Responsible Party Signature

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient (if applicable): _____

Witness / Staff Signature

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient (if applicable): _____

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GENERAL CONSENT TO DENTAL AND PERIODONTAL TREATMENT

Patient Name: _____ Date of Birth: _____

Today's Date: _____ Chart / Account #: _____

This form authorizes routine diagnostic and preventive/periodontal care at this practice. It does not cover surgical procedures such as implant placement, bone or soft tissue grafting, or osseous surgery, each of which requires its own procedure-specific informed consent that will be reviewed and signed separately before that treatment is performed.

Services Covered by This Consent

- Clinical examination, periodontal charting, and diagnostic radiographs (x-rays)
- Dental prophylaxis (cleaning) and periodontal maintenance
- Scaling and root planing (deep cleaning)
- Local anesthesia (numbing) administered for routine, non-surgical care
- Application of preventive agents such as fluoride or desensitizing agents
- Other routine, non-surgical periodontal treatment as recommended by your provider

Risks of Routine Care

As with any dental procedure, routine care carries some risk, including but not limited to: temporary tooth or gum sensitivity, minor bleeding or soreness, temporary numbness from local anesthesia, and, rarely, allergic reaction to materials or anesthetic agents used. I understand that periodontal disease is a chronic condition and that maintenance care reduces, but does not eliminate, the risk of disease progression.

No Guarantee of Outcome

I understand that dentistry and periodontal care are not exact sciences, and that no guarantee or assurance has been made regarding the outcome of any examination or treatment provided under this consent. Results can vary based on individual healing, oral hygiene, and other factors outside the practice's control.

Questions & Right to Refuse

I have had the opportunity to ask questions about the treatment described above and have received satisfactory answers. I understand that I may decline any recommended treatment and may request more information at any time before proceeding.

Financial Responsibility

I understand that financial responsibility for services rendered is addressed separately in this practice's Financial Policy & Payment Agreement, which I have reviewed and signed.

Patient Initials: _____ *I have read and understand this General Consent to Treatment and authorize the services described above.*

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Patient / Legal Guardian Signature

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient (if applicable): _____

Witness / Staff Signature

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient (if applicable): _____