MEDICAL HISTORY

Date: _________**Name:** ____ **Date of Birth:**___________ **Gender**: M F

Home Address: _______________________________________**City:**________________**State:**_______**Zip:**_________

Primary Phone #:( )______________ h /c /w **Secondary #:**( )_________________ h /c /w **SS#**______________

Employer: _______________________________ **Occupation:** _________________ **Email:**_______________________

Emergency Contact Name:______________________________ **Relation:**______________________

Primary Phone #:( )__________________ h /c /w **Secondary Phone:**( )_________________ h /c /w

How did you hear about us? Insurance Directory Internet Family/Friend/Co-worker_______________

Physician's Name:__________________________Phone #:( )______________Date of last visit:____________
Do you smoke or use tobacco in any other form? YES NO Have you been diagnosed with Sleep Apnea? YES NO
For Women: Are you Pregnant? YES NO Are you nursing? YES NO Are you taking birth control pills? YES NO
Have you ever been advised by a physician that you should premedicate with antibiotics for dental treatment? YES NO

Have you ever or do you now have any of the following medical conditions? Please circle. (Y=Yes, N=No)

Y N Abnormal Bleeding
Y N Anemia
Y N Sickle Cell Disease/Traits
Y N Hemophilia Type?_________
Y N Blood Transfusion
Y N Gastric Ulcers
Y N Arthritis
Y N Osteoporosis
Y N Artificial Joints When?_________
Y N Cancer/Chemotherapy
Y N Radiation Treatment
Y N TMJ/TMD
Y N Frequent Headaches/Migraines
Y N Epilepsy / Fainting Spells
Y N Seizures Last/Type? _________
Y N Thyroid Problem

Y N Heart Disease
Y N High Blood Pressure
Y N Low Blood Pressure
Y N High Cholesterol
Y N Stroke When?_________
Y N Heart Attack When?_________
Y N Heart Surgery When?_________
Y N Cardiac Stent When?_________
Y N Pacemaker When?_________
Y N Heart Murmur
Y N Congenital Heart Disease / Prosthetic Cardiac Valve/ Previous Infective Endocarditis/ Palliative Shunt or Conduit

Y N Bisphosphonate use? Oral or IV? (e.g. Fosomax, Actonel, Boniva, Zometa)
Y N Alcohol/Drug Abuse
Y N Hepatitis Type? _________
Y N HIV / AIDS
Y N Tuberculosis (TB)
Y N Herpes/Fever Blisters/Cold sores
Y N Kidney Problems/Disease
Y N Liver Disease
Y N Psychiatric Problem
Y N Diabetes
Y N Insulin Dependent
Y N Difficulty Breathing
Y N Asthma
Y N Emphysema

Any other medical condition(s)? YES NO If yes, please explain:____

____

Any prescription, over-the-counter, herbal or natural supplements? YES NO If yes, please list:________________

____

Do you have any allergies to medications? YES NO If yes, please circle:

Penicillin	Codeine	Metals	Keflex	Levaquin
Latex	Erythromycin	Tetracycline	Doxycycline	Motrin/Advil (ibuprofen)
Dental Anesthetics	Epinephrine	Clindamycin	Iodine	Z-Pack (azithromycin)

Please list any other drugs/materials to which you are allergic: ____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform my provider of any changes in my medical status.

Patient/Guardian Signature:______________________________________ Date:_________________________

For office use only:
Date: ___________ Initials: ____________ Comments: ____
Date: ___________ Initials: ____________ Comments: ____
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Date: ___________ Initials: ____________ Comments: ____
Date: ___________ Initials: ____________ Comments: ____

WEST HARTFORD FAMILY DENTISTRY, P.C.

342 North Main Street, Suite 300
West Hartford, CT. 06117
(860) 233-0552

Financial Policy

Thank you for choosing West Hartford Family Dentistry, P.C. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options: You can choose from:

- Visa, Mastercard, American Express, Discover Card or Cash, Check
- NO INTEREST[1] Payment Plans[2] from CareCredit
  - Allow you to pay overtime with NO INTEREST[1]
  - Convenient, low monthly payment plans[2] also available
  - No annual fees or pre-payment penalties

Please note:

We require payment in full on day of service. For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[3] We prepare and file the necessary forms for you electronically the same day so they'll receive it right away. We'll do our best to estimate your responsibility the day of the treatment, however, dental benefit plans do not guarantee benefits until claims are received and reviewed. However, estimated co-payments and deductibles are to be paid on day of service.

For co-payments of $500 or more, a 50% deposit is required to secure your initial treatment appointment.

A fee of $35 is charged for patients who miss or cancel an appointment without 24-hour notice. Should subsequent incidents occur, there would be a $75 charge. We charge $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and/or need.

____

Patient, Parent or Guardian Signature Date

____

Patient Name (Please Print)

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

[2]Subject to credit approval

[3]However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

April 2019

WEST HARTFORD FAMILY DENTISTRY, P.C.

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 4-15-03. 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 the 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 assessments and improvement activities, reviewing the competence 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 you 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 official's 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 practicably 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.

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 six years, but not before April 14, 2003. If you request this accounting more than once in a twelve-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 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 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 have 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 voice your concerns by 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 Officers: Cindy Seguro Telephone: (860) 233-0552 Fax: (860) 233-9614

Address: 342 North Main St. Suite #300 West Hartford, CT 06117

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of West Hartford Family Dentistry's Notice of Privacy Practices.

______________________________ ______________________________

Print name of patient Print name of parent if necessary

______________________________ ______________________________

Signature Date

WEST HARTFORD FAMILY DENTISTRY, P.C.
342 North Main Street, Suite 300
West Hartford, CT. 06117
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General Consent and Statement of Responsibility

I, (print name) ______________________________________ have been informed of the need to undergo dental treatment as presented to me.

I have been fully informed about the details of the recommended treatment and alternatives, and accept the treatment as recommended by the doctor. I understand that as the treatment proceeds there may be need to change the treatment plan. If this occurs I expect to be informed before any change is instituted. I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions during or following any treatment, I agree to report them to the office as soon as possible.

I have been told that the success of the recommended treatment depends upon my cooperation in keeping scheduled appointments, following home care instruction, including oral hygiene and dietary instructions, and reporting to the office any changes in my health status such as taking any prescribed medications as soon as possible.

I have discussed all the above with the Doctor / Hygienist, and all my questions have been answered. I acknowledge that no guarantees or assurances have been given by anyone as to the result that may be obtained.

I am aware that West Hartford Family Dentistry, P.C. cannot guarantee my receipt of benefits from the insurance company for treatment. I understand that any portion not covered by my insurance is my responsibility and any such balance is due payable upon the date services are rendered, unless written financial arrangements have been made. My signature confirms that I will assume full responsibility for my dependents' and my balance. I understand and agree that if my account is turned over for collection, I will be responsible for reasonable attorney fees and court costs. I understand that my failure to cancel scheduled appointments without at least 24 hours notice will result in charge as posted in the reception area.

____ ____

Patient Signature Date If minor, Signature of Parent or Guardian

____ ____

Witness Signature Doctor / Hygienist Signature

Annual updates:

Patient's Signature ____________________________________Date_______________

Patient's Signature ____________________________________Date_______________

Patient's Signature ____________________________________Date_______________

Patient's Signature ____________________________________Date_______________

April 2019