Date_____ **Confidential Responsible Party Information**

Name_____ Marital Status _____
Last First Middle
Residence_____ □ Own □ Rent
Street City State Zip
Mailing Address_____ Email_____
Street City State Zip
How long at this address_____ Previous address_____
(if less than 3 years) Street City State Zip
Home Phone_____ Work Phone _____ Cell Phone_____
Social Security # _____ Birthdate_____ Relationship to Patient_____
Employer_____ Occupation_____ No. of years employed _____
Spouse's Name _____ Relationship to Patient _____
Last First Middle
Employer _____ Occupation_____ No. of years employed _____
Social Security # _____ Birthdate _____ Work Phone _____

Confidential Patient Information

Patient's Name_____
Last First Middle
Address _____
Street City State Zip
Home Phone_____ Birthdate _____ Social Security # _____
If patient is a minor, give parent's or guardian's name _____
Whom may we thank for referring you to our office? _____

Insurance Information

Policy Holder's Name _____ Social Security # _____
Insurance Company_____ Group # _____ Union Local # _____
Insurance Co. Address_____ Insurance Co. Phone _____
Policy Holder's Employer _____
Do you have dual coverage? □ No □ Yes If Yes:
Policy Holder's Name _____ Social Security # _____
Insurance Company_____ Group # _____ Union Local # _____
Insurance Co. Address_____ Insurance Co. Phone _____
Policy Holder's Employer _____

Emergency Information

Name of nearest relative not living with you _____
Complete Address _____
Phone _____ Relationship _____

I understand that where appropriate, credit bureau reports will be obtained.
Signature (Parent's signature if minor) _____
Updates (date & initial) _____

The following information is necessary for proper diagnosis, treatment and records.
Answers to the following question are for our records only and will be considered confidential.
Please place an (X) before any of the following that apply to you.

__ Anemia
__ Asthma
__ Cancer
__ Radiation
__ Chemotherapy
__ High Blood Pressure
__ Low Blood Pressure
__ History of alcohol Addiction
__ History of drug Addiction
__HPV-Human Papilloma Virus
__ Herpes (cold sores)
__ Seizures
__Migraines/Headaches

__ Pregnancy
__ Due Date_____
__ Osteoporosis
__ Nervous Disorder
__ Depression
__ General Allergies
__ Penicillin Allergy
__ Sulfa Allergy
__ Latex Allergy
__ Metal Allergy
__ Drug Allergy
__ Novocaine Allergy
__ Arthritis
__ Diabetes Type 1__Type 2__
__ Rheumatic Fever

__Wear Pacemaker
__ Heart Attack
__ Heart Surgery
__ Artificial Heart Valve
__ Heart Murmur
__ Irregular Heartbeat
__ Mitral Valve Prolapse
__Stroke
__ Kidney Disease
__ Liver Disease
__ Hepatitis A B C
__ AIDS/HIV
__ Hip or Joint Replacement Date of Replacement _____
__ Metal or plastic bone replacement
__ Blood Transfusion Date _____

Indicate any illnesses not listed above: _____
Primary Care Physician and Phone Number: _____
Pharmacy: _____
Are you taking any medications now? Please include over the counter medications and vitamins:
_____

Are you taking birth control pills?	Yes No
Have you taken drugs for osteoporosis?	Yes No Oral IV
Are you subject to prolonged bleeding?	Yes No
Do you take Coumadin, Plavix, or Pradaxa? (Blood thinners)	Yes No
Do you take aspirin on a regular basis	Yes No
Have you ever had a cardiac work up?	Yes No
Have you ever had a reaction to epinephrine?	Yes No Type of reaction _____
Have you ever or do you taken antibiotics prior to dental visits?	Yes No _____
Have you ever had collagen injections?	Yes No
Have you ever taken corticosteroids?	Yes No
Have you a history or currently use tobacco?	Yes No

Dental History

Approximate date of your last dental visit _____ Approximate date of last full set of x-rays_____
Approximate date of last dental cleaning _____ Do your gums bleed? _____
Have you ever had treatment for gum disease? _____
Do you avoid any part of your mouth when eating or brushing? _____
Does food catch between your teeth? _____
Do you have any pain in your mouth? _____
Do you clench your teeth often? _____
Have you ever had local anesthetic (novocaine)? _____ Do you prefer it for fillings? _____
Do you have any teeth missing that were not replaced by bridgework, partial or full dentures, or implants? _____
Have you had orthodontic treatment? _____
Do you have any specific concerns you would like to discuss today? _____
_____
Medical Updates: _____
_____

Lifetime Family Dentistry
66 Maple Ave., Collinsville CT 06019

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 _____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 assessment 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 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 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. You may also request access by sending us a letter to the address at the end of this Notice.)

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_____. 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.

Restrictions: 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:	Maddy Doyon
Telephone:	860-693-8314
Fax:	869-693-4426
Address:	66 Maple Ave., Collinsville CT 06019

Lifetime Family Dentistry
66 Maple Ave, Collinsville CT, 06019

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

_____
For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice Of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify)

_____

_____

_____