

ENDODONTIC ASSOCIATES OF GREATER WATERBURY

Name: _____ Date: _____

DENTAL HISTORY

PLEASE CIRCLE as relates to your tooth.

Pain (present)	Pain (past)	No Pain	Can localize pain			
Headache	Earache	Swelling	Gum tenderness			
Hot sensitive	Cold sensitive	Air sensitive	Biting/touch sensitive			
How long have you been in pain? _____		How long does it last? _____				
Pain is: Constant	Comes & Goes	Spontaneous	Radiating	Severe	Dull ache	Throbs

Additional information: _____

MEDICAL HISTORY

Primary Care Physician's name: _____

Have you had any serious illnesses or operations? YES / NO

If yes, describe _____

Are you currently under a physician's care? YES / NO If yes, describe _____

List medications you are currently taking _____

Are you allergic to: **ASPIRIN, IBUPROFEN, LATEX, NOVOCAINE, PENICILLIN**

OTHER: _____

PLEASE CIRCLE if you have any of the following:

Anemia	Glaucoma	Radiation Treatment	Arthritis
Headaches	Respiratory Disease	Artificial Heart Valve	Heart Murmur
Rheumatic Fever	Artificial Joints	Heart Problems	Sinus Problems
Asthma	HIV/AIDS	Stroke	Blood Disease
Abnormal Bleeding	Surgical Implant	Cancer	Hepatitis A, B or C
Thyroid Disease	Chemotherapy	High Blood Pressure	Tuberculosis
Cough, Persistent	Kidney Disease	Ulcer/Colitis	Diabetes
Liver Disease	Epilepsy	Pacemaker/Heart Surgery	Mitral Valve Prolapse
Presently Pregnant	OTHER: _____		

SIGNATURE _____

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HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out treatment, payment and healthcare operations.

- Treatment including direct or indirect treatment by other healthcare providers involved in my case.
- Payment: We may use and disclose your health information to obtain payment for services we provide to you.
- The day-to-day healthcare operations of our practice in relation to your treatment

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice periodically and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restriction on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, then you are bound to comply with the restriction.

I understand that I may revoke this consent in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Endodontic Associates may release information on my health to the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

Print Patient Name: _____

Relationship to Patient: _____

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PATIENT INFORMATION

Welcome to our office.

Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be happy to help you.

Mr/Ms/Mrs _____ (Last Name) (First Name) (MI)

Street _____ City _____ State _____ Zip _____

Cell (_____) _____ Home (_____) _____ Work (_____) _____

Please call: Cell Home Work

If unable to reach me: Leave a Detailed Message Leave a message asking me to return your call

Email _____ Date of Birth _____

Occupation _____ Employed by _____

Spouse _____ Employed by _____ Phone (_____) _____

Notify in case of emergency _____ Phone (_____) _____

Your general dentist _____

PRIMARY DENTAL INSURANCE

Carrier _____ Group # _____

Subscriber _____ ID#/SS# _____ DOB _____

SECONDARY DENTAL INSURANCE

Carrier _____ Group # _____

Subscriber _____ ID#/SS# _____ DOB _____

Today I will be paying by (please circle one) Cash Check Credit Card

AUTHORIZATION

I authorize the insurance companies listed above to pay the dentist all insurance benefits otherwise payable to me for the services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that REGARDLESS what my insurance pays, I am financially responsible for this account and I have read the financial policy on the back of this form.

Signature _____ Date _____

Please print name _____