ADVANCED PERIODONTICS

60 Washington Avenue, Suite 207
Hamden, Connecticut 06518
Phone: 203-288-5916 Fax: 203-230-1213

Name_____Referring Dentist_____

Address_____City,State_____Zip_____

Date of Birth:_____Social Security #_____

Home Phone: _____ Bus. Phone: _____Cell: _____

Email:_____ Occupation:_____

Contact in Case of Emergency_____Phone:_____

Physician's Name_____Phone_____

Date of last physical _____

Are you now or have you recently been under a physician's care_____

For What Reason_____

Check ( ) if you have had any of the following:

( ) Anemia
( ) Blood Transfusion
( ) Artificial Heart Valve
( ) Lung Disease
( ) Abnormal Bleeding
( ) Sinus Trouble
( ) Chest Pain
( ) Pneumonia
( ) Abnormal Heart Condition
( ) Asthma or Hay Fever
( ) Shortness of Breath
( ) Diabetes
( ) Heart Surgery
( ) Stroke
( ) Covid 19
( ) Rheumatic Fever
( ) Frequent Thirst or Urination
( ) Heart Pace Maker
( ) Severe Headaches
( ) Mitral Valve Prolapse
( ) Epilepsy/ Seizures
( ) High/Low Blood Pressure
( ) Arthritis
( ) Heart Murmur
( ) Fainting Spells
( ) Stomach Ulcers
( ) Artificial Joint
( ) Thyroid Disease
( ) Tumor/Malignancy
( ) Kidney or Bladder Trouble
( ) Radiation Therapy
( ) Liver Disease
( ) Chemotherapy
( ) History of bisphosphonate injections
( ) Hepatitis
( ) Drug or Alcohol Addiction
( ) Immune Deficiency
( ) Neurological Disorder
( ) Latex Allergy
( ) Hemophilia
( ) Glaucoma
( ) Cancer
( ) Heart Attack
( ) Other _____

PHARMACY:_____

Do you smoke tobacco? YES NO If so, how much? _____

Allergies: ( ) Local Anesthetics ( ) Aspirin ( ) Antibiotics _____
( ) Sleeping Pills ( ) Codeine ( ) Metals _____
( ) Latex ( ) Iodine ( ) Foods _____

List ALL medications you are currently taking, if any_____

Have you ever taken antibiotics before dental procedures? YES NO

Women only: Are you pregnant? _____ How many months? _____ Are you breast feeding? _____

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge.

Signature_____Date_____

HEALTH INFORMATION PRIVACY POLICIES & PROCEDURES

Recently, the federal government put in place national standards to protect your right to privacy with regard to healthcare information. We take our responsibility to safeguard your healthcare information and inform you of your rights very seriously. In order to make your rights understandable we have developed a readable summary explanation of your rights. You will be asked to sign a form acknowledging having received this information.

I. How we may use your Protected Health Information (PHI).

A. Treatment - In order to provide you with appropriate treatment, we may share information with referring dentists or medical personnel involved in your care. Some information such as HIV status, drug and alcohol dependence and mental health status are entitled to special restrictions related to its use and disclosure.

B. Payment - Treatment rendered may be shared with insurance companies, third party payees and family members who are taking responsibility for payment.

C. Appointment Reminders; **Explanation of Insurance Benefits:** - We may mail this information to your address of record; we may call your home or office and relate this message directly or leave it on an answering machine or with the individual who answers the phone, or we may e-mail or fax this information.

D. Workers Compensation Claims

E. Public Health Risks

F. Law Enforcement Agencies/Lawsuits when provided with proper authorization.

II. Your Rights Regarding your PHI

A. Right to **inspect and copy dental records**

B. Right to **request an addendum to your dental records if you believe they are incorrect**

C. Right to an **accounting of disclosures of medical information** for purposes other than treatment or payment once (over a 12-month period).

D. Right to **request restrictions on medical information we disclose about you.**

E. You have the right **to request that we communicate with you about dental matters and appointments in a certain way or certain location** and we will accommodate all reasonable requests.

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

PATIENT BILLING & DENTAL INSURANCE INFORMATION

PATIENT'S NAME:_____Date:_____

NAME OF PERSON TO RECEIVE BILL: _____

ADDRESS:_____

PHONE NUMBER:_____

- **I UNDERSTAND THAT I AM FINANCIALY RESPONSIBLE FOR ANY AND ALL CHARGES.**

- **I UNDERSTAND THAT CERTAIN OR ALL CHARGES MAY NOT BE COVERED BY MY INSURANCE AND I AM FINANCIALLY RESPOSIBLE FOR ALL CHARGES INCURRED.**

- **I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE PAYMENT OF BENEFITS TO THE PHYSICIAN OR SUPPLIER FOR SERVICES RENDERED.**

SIGN:_____DATE_____