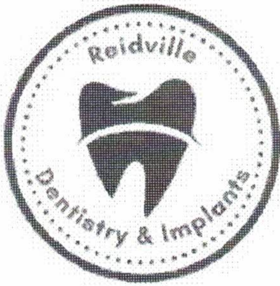

Welcome
to our practice

Patient Information

Date______________ Soc. Sec. #______________ Birthdate______________

Name______________________________________ Home Phone______________
Last Name First Name Middle Initial

Address______________________________________ Cell Phone______________

City______________ State________ Zip________ Email______________

Sex ☐M ☐F ☐Minor ☐Single ☐Married ☐Long Term Partner ☐Divorced ☐Widowed ☐Separated

Employer______________________________ Business Phone______________

Business Address______________________________ Occupation______________

How did you hear about us?______________________________________

In case of emergency who should we contact?______________ Phone______________

Primary Dental Insurance

Person responsible for plan______________________________________
Last Name First Name Middle Initial

Relationship to patient______________ Birthdate______________ Soc. Sec. #______________

Address______________________________________ Phone Number______________

City______________ State________ Zip________

Employer______________________________ Business Phone______________

Business Address______________________________ Occupation______________

Insurance Company______________________________________

Insurance Company Address______________________________________

Subscriber/Member I.D. #______________________ Group #______________

Additional Insurance______________________________________

HIPAA Information

I hereby acknowledge receipt of HIPAA privacy regulations. *copies available upon request*

Patient or Parent/Guardian Signature______________________________________

With whom do you authorize us to share your personal dental information?

Name______________ Relationship______________ Phone______________

Name______________ Relationship______________ Phone______________

I understand that it is my responsibility to notify the office of any changes such as a new address, name change, phone numbers, email address, new insurance, etc.

Patient or Parent/Guardian Signature______________________________________

Name Printed______________________ **Date**______________

Dental History

Former Dentist________________________ How often do you brush?__________

City, State ________________________ How often do you floss?__________

Date of last dental visit__________ Date of last x-rays__________ Date of last cleaning__________

Please check all that apply:

____Bad Breath	____Loose Teeth or Broken Fillings	____Sensitivity to Sweets
____Bleeding Gums	____Orthodontic Treatment	____Sensitivity When Biting
____Blisters on Lips/Mouth	____Pain Around Ear	____Frequent Headaches
____Nail Biting	____Periodontal Treatment	____Jaw, Head, or Neck Injury
____Grinding Teeth	____Sensitivity to Cold	____Jaw Clicking and/or Pain
____Lip/Cheek Biting	____Sensitivity to Heat	____Tooth Pain

Medical History

Physician's Name__________________ Phone #______________ Date of Last Visit__________

1. Are you currently under medical supervision? **Y/N**
2. Have you ever had any serious illnesses or operations?............ **Y/N**
3. Are you currently taking any medications?........ **Y/N**

Please list:______________________

____

____

____

4. Do you smoke?............ **Y/N**

How much/often? ______________

5. Do you drink alcohol?............ **Y/N**

How often? __________

6. **Have you had any allergic reactions to the following:**

Local Anesthetics (eg. novocaine) ....**Y/N**

Penicillin ....**Y/N**

Sulfa Drugs ....**Y/N**

Iodine ....**Y/N**

Aspirin ....**Y/N**

Other:______________________

____

7. (Women Only) Are you:

Pregnant?..........**Y/N**

Nursing?..........**Y/N**

Taking Birth Control?.....**Y/N**

Please Check All That Apply

____AIDS	____Congenital Heart Lesions	____Jaundice	____Sinus Problems
____Anemia	____Cortisone Treatments	____Jaw Pain	____Skin Rash
____Arthritis/Rheumatism	____Cough-Persistent or Bloody	____Kidney Disease	____Stroke
____Artificial Heart Valves	____Diabetes	____Latex Sensitivity	____Swelling of Feet/Ankles
____Artificial Joints	____Emphysema	____Liver Disease	____Swollen Neck Glands
____Asthma	____Epilepsy	____Low Blood Pressure	____Thyroid Problems
____Back Problems	____Fainting or Dizziness	____Mitral Valve Prolapse	____Tonsilitis
____Bleeding Abnormally w. Extractions or Surgery	____Glaucoma	____Nervous Problems	____Tuberculosis
	____Headaches	____Pacemaker	____Tumor/Growth on Head/Neck
____Blood Disease	____Heart Murmur	____Psychiatric Care	
____Cancer	____Heart Problems	____Radiation Treatment	____Ulcer
____Chemical Dependency	____Hepatitis-Type___	____Respiratory Disease	____Venereal Disease
____Chemotherapy	____Herpes	____Rheumatic Fever	____Other__________
____Chronic Fatigue Syndrome	____High Blood Pressure	____Scarlet Fever	
____Circulatory Problems	____HIV Positive	____Shortness of Breath	

Assignment and Release

I hereby authorize payment directly to Reidville Dentistry & Implants for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the release of information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party______________________ **Date**______________

Reidville Dentistry & Implants LLC

464 Reidville Drive, Suite A2
Waterbury, CT 06705
(203) 575-9120

Method of Payment

Payment is expected on the day service is provided. We will be glad to submit to your insurance company; however, after 90 days if the balance is unpaid, it becomes the responsibility of the patient/insured to follow up with their insurance company.

We accept local (CT) checks, money orders, cash, and major credit cards.

Delinquent accounts transferred to collections will be assessed a fee up to 40% of the unpaid balance.

Returned checks are assessed a minimum fee of $50.00.

Broken Appointments

Missed appointments are a hardship for everyone, including the patient. Our policy requires 24 hour notice to change or cancel an appointment. Your insurance company is not responsible nor will they be billed for missed appointments. Appointments broken without 24 hour notice are subject to a $50.00 charge and may result in the termination of treatment.

Duplicate Records

Reidville Dentistry & Implants LLC will be glad to forward your records upon your written authorization that should include the name and address of your current dentist.

Radiographs (x-rays) may be forwarded at no charge to another provider. A minimum of five (5) working days is required for this service.

Patient Signature________________________________ **Date**____________

Reidville Dentistry & Implants LL

Informed Consent for Routine Dental Treatment

In order to provide comfortable dental treatment it is often necessary to administer local anesthesia (Novocaine, Lidocaine, etc.) by injection. This is a commonly performed procedure in dental offices and usually carries very little risk, however, there are risks associated with its use.

Possible complications include but are not limited to:

*Local pain and/or infection
*Temporary but potentially permanent numbness or altered sensation to the nerve that goes to the lip, tongue, gum, etc.
*Systemic (whole body) reaction including allergic reaction

Additionally, pain or prolonged discomfort to the jaw joints (TMJ) may occur from treatment. This is a known complication due to wide opening and stress on the jaw joints. Although usually temporary, discomfort and restricted jaw movements for some time might occur.

By my signature, I attest that I have read and understand this consent to have local anesthesia administered as necessary and to have routine dental procedures performed. I have provided an accurate history of my medical and dental status including all medications I am taking.

_______________________________ _______________________________ __________

Patient Signature Print Name (Patient) Date

_______________________________ _______________________________

Signature of Guardian (if minor) Relationship

____

Office Staff/Witness