Trumbull Smiles Family Dental, LLC
160 Hawley Lane Suite 103
Trumbull, CT 06611
203-220-6610

Patient Information

Patient Name: ____ Date: __________

Last First MI (preferred name)

Gender:____________ Family Status:______________________(Single, Married, Child)

Social Security #: ______________________ Birth Date: ____________________

Phone (Home): __________________(Work): _____________________(Cell): ______________________

Email address____

Address: ____

Street Apartment #

____

City State Zip Code

Health Information

Date of Last Dental Visit: _________ Reason for this visit: ____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies ________ ________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy** Due Date: _______
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ ____________
- ☐ ____________

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: ____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain: ____

- Are you now under the care of a physician? ☐ Yes ☐ No

If yes, please explain: ____

- Name of physician:__________________________________ Phone: _______________________________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: ____

____

____

Please list any medications you are currently taking:____

____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: _____________________

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice?

☐Another patient, friend ☐Another patient, relative ☐Dental Office ☐Yellow pages ☐Newspaper ☐School ☐Work

☐Insurance Company ☐Other ______________________________________

Name of person or office referring you to our practice: ____

Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the patient's parent ☐ the patient's legal guardian ☐ the person responsible for payment

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____________

Social Security #: ____ Birth Date: _________________________________

Phone (Home): _______________________(Work): _________________________(Cell): ________________________

Address: ____

Street apartment #

____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ___________________________________ Occupation: ____

Address ____

Insurance Information

Primary

Name of Insured:____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ___________________ ID #:________________________ Group #:___________________________

Insured's Address: ____

Street City State Zip Code

Insured's Employer Name: ____

Address: ____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________________

Insurance Plan Name and Address: ____

____

Secondary

Name of Insured:____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ___________________ ID #:________________________ Group #:___________________________

Insured's Address: ____

Street City State Zip Code

Insured's Employer Name: ____

Address: ____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________________

Insurance Plan Name and Address: ____

____

Trumbull Smiles Family Dental, LLC
Scott D. Cohen, D.D.S.
160 Hawley Lane Suite 103
Trumbull, CT 06611

Notice of Privacy Practice Acknowledgement

I understand that under the Health Insurance Portability Act of 1998 (HIPPA). I have certain rights to privacy regarding my protected Health information. I understand that this information can and will be used to:

-Conduct plans and direct my treatment and follow up among the multiple Healthcare Provides who may be involved in that treatment directly and indirectly.

-Obtain payment from Third-Party Payers.

-Conduct normal Healthcare Operations such as Quality Assessments and Physician Certifications.

I have received, read and understand your Notice of Privacy containing a more complete description of the users and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practice from time to time and that I may contact this organization at any time at the address above to obtain a current copy of Notice of Privacy Practice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or Healthcare Operations. I also understand you are not required to agree to my requested restrictions. But if you do agree then you are bound and abided by such restrictions.

Patient Name: ______________________________

Relationship to Patient: _______________________

Signature: ___________________________________

Date: ____

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practice Acknowledgement, but was unable to do so as documented below:

Date:________________________ Signature:_______________________________

<u>Missed Appointment Policy</u>

Our practice takes pride in our dentistry, and our time as well as our patients' time is valuable. We set aside time specifically for each patient who is scheduled. As such, we have a strict policy for each patient who is scheduled: we require **24 hours'** notice if you are unable to make your appointment. If you miss an appointment without notification you will be dismissed from our practice. There are few exceptions to this rule.

Following dismissal from our practice, we will only be able to provide service for the next 30 days to allow you time to find another dentist to whom we will transfer your records.

I understand and agree to Trumbull Smiles Family Dental, LLC's policy on missed appointments:

___________________________ ________________

Patients Name Date

___________________________ _________________

Patient's (or legal Guardian's Signature Date