The Dental Center LLC.

XRAY AND RECORDS RELEASE FORM

PLEASE COMPLETE AND SEND OUT TO YOUR PREVIOUS DENTIST AS SOON AS POSSIBLE.

Date:
Name:
Address:
Date of Birth:

I hereby request and authorize **Dr.** _______________ to transfer my Dental Records and X Rays to:

The Dental Center, LLC
David P. Bell, D.M.D.
Barbara Honor D.M.D.
Brian Bell D.M.D.

Please circle the Dental Office address where you want your x-rays sent :

2304 Berlin Turnpike
Newington, Ct 06111
860 666-1000
860 666-0090 fax
dpbelldmd@gmail.com

42 Wintonbury Mall
Bloomfield, Ct 06002
860- 242-1230
860 -242-8477 fax
bhonordmd@gmail.com

CONFIDENTIAL HEALTH HISTORY

Patient Name: ______________________________ Date of Birth: ______________

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1.) YES NO Is your general health good?
If NO, explain ______________________________

2.) YES NO Has there been a change in your health within the last year?
If YES, explain ______________________________

3).YES NO Are you being treated by a physician now? If YES , explain ______________________________

Name of physician:______________________ Date of last medical examination ______________

II. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please Circle)

Damaged heart valve	Eating disorder	Cancer/ tumor	Tobacco habit
Artificial heart valve	Acid reflux disease	Chemotherapy or radiation	Seizures
Heart attack/ disease	Kidney disease	Arthritis	Skin disease
Pacemaker	Diabetes	Skin disease	Herpes
High blood pressure	Asthma	HIV or AIDS	Artificial joint
Stroke	Hay Fever	Sexually transmitted disease	Cosmetic surgery
Headaches/ migraines	Tuberculosis	Psychiatric problems	Osteoporosis
Blood disorder	Persistent Cough	Chemical dependency	Surgery:______________
Hepatitis/ liver disorder	Emphysema	Alcohol dependency	______________
Digestive problems	Lung disease	Sleep Apnea	______________

III. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please Circle)

Aspirin	Penicillin	Antibiotics	Latex
Local anesthetic	Novacaine	Codeine	Food

Other allergies: ______________________________

IV. MEDICATIONS AND PRESCRIPTIONS: Please list supplements, prescription or recreational drugs you are taking:

____

____

V. WOMEN ONLY

YES NO Are you or could you be pregnant? YES NO Are you nursing? YES NO Are you taking birth control pills?

VI. ARE YOU TAKING OR HAVE YOU EVER TAKEN ANY OF THE FOLLOWING? (Please Circle)

Recreational drugs	Tobacco in any form	Antibiotics	Aspirin
Coumadin	Plavix		

IV or Oral Bisphosphonate: Fosomax, Actonel, Boniva, Reclast, Didronel, Zometa, Skelid, or others.

VII. ALL PATIENTS

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: ______________________________

Yes No Have you ever been pre-medicated for dental treatment? If YES, why ______________________________

Yes No Have you ever taken Fen-phen? If YES, when ______________

Yes No Is there any issue or condition that you would like to discuss with the dentist in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potential medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my physician. I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (parent or guardian)______________________ **Date**______________

Spouse or Responsible Party Information

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

Name: ______________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): ______________ (Work): ______________ Ext:______ Best time to call: ____________

Address: ______________________________

Street Apartment #

____

City State Zip Code

Employment Information

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

Employer Name: ______________________ Occupation: ______________________

Address: ______________________________

Street City State Zip Code

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: ______________________________

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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: ______________________________

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Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

______________________________ Date: __________ Relationship to Patient: ______________

Signature of patient, parent or guardian

______________________________ Date: __________ Relationship to Patient: ______________

Signature of guarantor of payment/responsible party

Images Release

I give the dental practice the absolute right and permission to use, copyright and/or publish, images, film or photographic portraits of me, or those in which I may be included in whole or in part, or composite in form or character, or reproductions thereof in color or otherwise, made through any media, for patient education, art, advertising, trade or any other lawful purpose.

Furthermore, I hereby waive any right to inspect and/or approve the finished product or the copy that may be used in connection therewith, or the use to which it may be applied.

I hereby release, discharge, and agree to save the practice, the doctor(s) and staff from any liability for any blurring, distortion, optical illusion, alteration, or use in composite form, whether intentional or otherwise, that may occur or be produced in the taking of said pictures, or in any processing tending towards the completion of the finished product.

Patient's Name: ____

Address: ____

____

signed,	signed,	signed,
______________________	______________________	______________________
Patient	Parent/Guardian (required if patient is a minor)	Witness
______________________	______________________	______________________
Date	Date	Date

DENTAL QUESTIONNAIRE

Name: ______________________________________ Date: _______________

Correct answers to the following questions will allow us to render optimum health service on an individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered ***confidential****.*

1. Purpose of dental appointment: ____

2. Are you having discomfort at this time? ____

3. When was your last dental appointment? ____

4. What was done then? ____

5. When was your last dental cleaning? _____________________ Last dental x-rays_____________

6. Have you ever experienced: (please circle)

Extraction complication………… YES NO
Sores or lumps in mouth ………. YES NO
Difficulty chewing,………………..YES NO
Clicking or locking of the jaw …. YES NO
Jaw pain…………………………. YES NO
Headaches or Migraines…..…… YES NO
Bad Breath…………………………YES NO

Clenching or grinding of teeth….. YES NO
Braces (orthodontia)……………. YES NO
Bleeding gums…………………… YES NO
Gum (periodontal) treatment…… YES NO
Loose teeth ……………………… YES NO
Sensitive teeth …………………. YES NO
Problems with Novacaine………. YES NO

7. Do you have removable dentures or partial dentures? YES NO
   If yes: How do they work for you? ____

9. Do you use (please circle): Water pic, Electric toothbrush, Fluoride rinse, Mouthwash

10. Are you interested in whiter teeth? ____

11. How satisfied are you with the appearance of your smile? __________________________________

12. Has a dentist done anything you disliked in the past? YES NO
    If yes, please describe: ____

13. What would you like to change about your teeth?____

14. Any other questions or comments about your dental care? _________________________________

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NOTICE OF PRIVACY PRACTICES

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 April 27, 2009, 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 a 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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.75 for each page, $20.00 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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 April 14, 2003. 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.

Restriction: 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.

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