HOUSATONIC VALLEY DENTAL CARE

60 Church Street • P. O. Box 607 • Canaan, CT 06018
860.824.5101

Chart#_____ How did you hear about _____
For Office Use Only

Patient Name: _____ _____ _____ _____
Last Name First Name MI Preferred Name

Family Status: ☐Married ☐ Single ☐ Child Other

Birth Date: _____/_____/_____ SS#:_____

Email Address:_____

Phone: _____ _____ _____
Home Cell Work

Mailing Address: _____ _____ _____ _____
Street /PO Box City State Zip

If Different Physical Address: _____ _____ _____ _____
Street /PO Box City State Zip

Emergency Contact: _____ _____
Name Phone Number (s)

Responsible Party Information: ONLY needs to be filled out if the insurance subscriber is other than patient OR you are the Parent/Guardian of the patient.

The following is for: the patient's spouse the person responsible for payment both neither-not applicable

Patient Name: _____ _____ _____ _____
Last Name First Name MI Preferred Name

Family Status: ☐Married ☐ Single ☐ Child Other

Email Address:_____

Phone: _____ _____ _____
Home Cell Work

Mailing Address: _____ _____ _____ _____
Street /PO Box City State Zip

Dental Insurance

Primary

Name of Insured: : _____ _____ _____
Last Name First Name MI

Insured's Birth Date: _____ ID#_____ Group#_____

Insured's Address: : _____ _____ _____ _____
Street /PO Box City State Zip

Insured's Employer Name:_____

Insured's Employer Address: :_____ _____ _____ _____
Street /PO Box City State Zip

Patient's relationship to Insured: ☐Self ☐Spouse ☐ Child ☐ Other

Insurance Plan Name:_____
Insurance Plan Address: _____ _____ _____ _____
Street /PO Box City State Zip
Insurance Company Phone number: _____

Insurance Authorization: ☐ By checking this box, I authorize my insurance company to pay the dentist all insurance benefits rendered. I authorize the use of this electronic signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Secondary

Name of Insured: : _____ _____ _____
Last Name First Name MI

Insured's Birth Date: _____ ID#_____ Group#_____

Insured's Address: : _____ _____ _____ _____
Street /PO Box City State Zip

Insured's Employer Name:_____

Insured's Employer Address: :_____ _____ _____ _____
Street /PO Box City State Zip

Patient's relationship to Insured: ☐Self ☐Spouse ☐ Child ☐ Other

Insurance Plan Name:_____
Insurance Plan Address: _____ _____ _____ _____
Street /PO Box City State Zip
Insurance Company Phone number: _____

Insurance Authorization: ☐ By checking this box, I authorize my insurance company to pay the dentist all insurance benefits rendered. I authorize the use of this electronic signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Medical History

Check the box if you have or have had any of the bellow listed conditions.

	Actonel, Risedronate		Allergy – Codeine		Allergy – Erythromycin		Allergy – Other Drug
	Allergy – Other		Allergy – Penicillin		Anemia		Arthritis
	Artificial Heart Val		Artificial Joints		Aspirin Sensitivity		Asthma
	Blood Disease		Blood Thinners		Cancer		Coumadin
	Fainting		Fosamax, Alendronate		Glaucoma		H.I.V.
	Hay Fever		Head Injuries		Heart Disease		Heart Murmur
	Hepatitis		High Blood Pressure		Implants		Intestinal Problems
	Jaundice		Kidney Disease		Latex Allergy		Liver Disease
	Low Blood Pressure		M.V.P.		Nervous Disorders		No Epi
	Other		Pacemaker		Pregnancy		PRE MED
	Prosthetic Device		Psychiatric Care		Radiation Treatment		Respiratory Problems
	Rheumatic Fever		Rheumatism		Sinus Problems		Stomach Problems
	Stroke		Tuberculosis		Tumors/Growths		Ulcers
	Venereal Disease		Hospitalized for illness/injury		Subject to frequent headaches		Tobacco/Alcohol Use
	Wounds healing slowly		Head or jaw injury		Treatment with Bisphosphonates		SENSITIVITY TO PAIN MEDICATION
	Presently being treated for any other illnesses		Taking contraceptives		Using Hormone Replacement Therapy		Pregnant or planning pregnancy
	Nursing						

If any conditions or alerts selected above need further clarification, please describe:

DO YOU TAKE ANTIBIOTIC PREMEDICATION FOR DENTAL VISITS? If yes please explain.

Describe any current medical treatment, impending surgery or other treatment that may possibly affect your dental treatment.

If you have had an orthopedic total joint replacement (hip, knee, elbow, finger), please describe below. Include any complications from procedure.

List all medications (prescription and nonprescription), vitamins and regular doses of aspirin.

What is your estimate of your general heath? Please circle one. Excellent Good Fair Poor

Name & Phone number of Physician/Date of last exam	Name & Phone number of preferred pharmacy

Approximate date of most recent dental exam and dental x-rays:

Previous Dentist Name and Phone number:

I routinely see my dentist every (circle one):

3 months 4 months 6 months 12 months Not routinely

What is your immediate concern?

Is there anything about the appearance of your smile that you would like to change?

	Had complications from past dental treatment		Had trouble getting numb		Had any reactions to local anesthetic
	Had/have braces, orthodontic treatment		You Experience dry mouth		Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
	Food gets trapped between any teeth		Have you ever whitened or bleached you teeth		Have you experienced popping and/or clicking of your jaw joint
	You have difficulty chewing		You clench or grind your teeth		You wear or have worn a bite appliance
	Gums bleed when brushing or flossing		Treated for gum disease or were told you have lost bone around your teeth		Noticed an unpleasant taste or odor in your mouth
	Experienced gum recession		Had any teeth become loose on their own		Experienced a burning sensation in your mouth
	You snore or wake up frequently during the night		Pain in or near ears		Unhealed injuries or inflamed areas
	Prolonged bleeding following extractions		Currently have any dental implants, partials or dentures		

If any of the checked boxes need further explanation, please describe:

I acknowledge that I have reviewed ALL Questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

_____ _____

Printed Name Signature

_____

Date

Financial Policy

I understand that I am responsible for the payment of all of the fees for my dental care.

We will submit any claims to your insurance company in a timely manner. However, we act solely as our agent in filing for your insurance payment. You are ultimately responsible for your entire balance including deductibles, procedures not covered by your policy and any balance remining after insurance payment.
I authorize the assignment of my insurance payments to Housatonic Valley Dental Care, P.C.
I authorize the staff of Housatonic Valley Dental Care. P.C. to discuss my insurance claims and my dental plan with my insurance company.

You may request an estimate of the fees for any recommended treatment. We will make very effort to make the estimate as accurate as possible and to inform you of any changes in the treatment plan. Estimates can only be extended for a period of six months from the date of the patient examination.

We offer several payment plans to help you finance your care. Payment plans must be finalized before treatment can begin. If no payment plan is in place when treatment is started, we will assume that you will be making payment in full for each service at the time of that service. Please speak to any staff member if you would like to finance the fees for your care.

After 60 days a late payment fee of 1% is added monthly (12% yearly)

I have read and understand the terms of this financial agreement.

☐By checking this box, I understand the above information and agree with its contents, and this will serve as my signature for the Administration Form.

HIPAA Acknowledgment

I understand that I may inspect or copy the protected health information described by this authorization.
I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affecte4d if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and if so may not be subject to federal or state law protecting its confidentiality.

☐By checking this box, I understand the above information and agree with its contents, and this will serve as my signature for the HIPAA Disclosure Form.