FAIRFIELD DENTAL CENTER – PATIENT INFORMATION

Please complete the following confidential form.
The information provided is important to your dental health and helps treating you for dental services.

Patient's name _____ Birth date_____ If minor, parents names _____
Home phone _____ Cell phone _____ Email _____
Mailing address _____ City _____State ___Zip _____
Driver's License # _____ Social Security #_____
Employer _____ Occupation _____
Employer Address _____ Work phone_____

❑ Single ❑ Divorced ❑ Widowed ❑ Married
Spouse's name _____
Employer _____ Occupation_____
Employer Address _____ Work phone _____

Emergency Contact Name and Phone Number_____
Whom may we thank for referring you to our office? _____

❑ Not covered by dental insurance
PRIMARY INSURANCE
Insurance Name _____ Group number_____ Social Security # _____
Address _____ Phone _____
Insured Name _____ Insured Social Security #_____
SECONDARY INSURANCE
Insurance Name _____ Group number_____ Social Security # _____
Address _____ Phone _____
Insured Name _____ Insured Social Security #_____

DENTAL HEALTH HISTORY

Why have you come to the dentist today? _____
Date of last dental visit _____ Reason _____
Have you ever fainted during dental treatment, had allergic reactions, abnormal bleeding or other complications? If so, explain: _____

What would you change about your smile? _____
Do your gums bleed?..... ❑ Yes ❑ No
Have you had any periodontal (gum) surgery?..... ❑ Yes ❑ No
Have your teeth moved or become loose?..... ❑ Yes ❑ No
Are your teeth sensitive to hot, cold, or pressure?..... ❑ Yes ❑ No
Do any of your teeth ache?..... ❑ Yes ❑ No
Do you grind or clench your teeth?..... ❑ Yes ❑ No
Do you have pain or clicking in the jaw joint around your ear?..... ❑ Yes ❑ No
Are there any sores or growths in your mouth?..... ❑ Yes ❑ No
Do you have any other specific dental concerns?_____
How often do you brush your teeth? _____ Do you floss?..... ❑ Yes ❑ No

MEDICAL HEALTH HISTORY

Physician's name _____ Phone Number _____
Date of last visit to physician and reason_____
Do you now or have you ever taken any illegal drugs (list)?_____

Check if you have/had any of the following

- ❑ Cancer or tumor
- ❑ Radiation treatment
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung or breathing problems
- ❑ Kidney disease or dialysis
- ❑ Glaucoma
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spell
- ❑ Emotional/psychological condition
- ❑ Arthritis
- ❑ Any autoimmune disease
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Stroke
- ❑ Asthma
- ❑ Emphysema

Do you smoke or use chewing tobacco?

❑ Yes ❑ No

Have you ever had any surgery (list)?

❑ Yes ❑ No

_____
_____

Are you allergic to or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin
- ❑ Clindamycin
- ❑ Erythromycin
- ❑ Local anesthetics ("Novocain")
- ❑ Narcotic pain medications
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you using or taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Inhalers
- ❑ Osteoporosis medicine (bone density)

List all medications you are taking below:

_____
_____
_____
_____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or birth control pills (some medications decrease their effectiveness)

Do you have any other medical conditions or problems not listed above?

_____
_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is **my responsibility to inform the office of any changes to my medical status or dental insurance as soon as possible**. I authorize the dental staff to perform any necessary dental service with my informed consent. I understand that **I am responsible for the entire bill even if I have dental insurance**. Permission to release information: I grant the right to the staff of FAIRFIELD DENTAL CENTER to release health information obtained from me and information about my dental treatment to third-party payers and/or other health practitioners.

Patient signature (or parent) _____ Date _____

Dentist signature _____ Date _____

PATIENT CONSENT FORM

FAIRFIELD DENTAL CENTER
271 RT 46 WEST SUITE-D-108
FAIRFIELD NJ 07004
Phone: (973) 227-1414
Fax: (973) 227-2322

I understand that under the Health Insurance & Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected dental and health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers 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 been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my dental/health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

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 dental/healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name _____

Patient Signature _____

Relationship to Patient _____

Date _____

FAIRFIELD DENTAL CENTER - NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance and Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical/dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

If you sign a Consent Form, we may use and disclose your medical/dental records only for each of the following purposes: treatment, payment, and health care operations. We do not sell patient lists.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of this would include teeth cleaning services or referrals to other dentists.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your health insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or health care operations in the following circumstances:

- In emergency treatment situations, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment;
- If we are required by law to treat you, and we attempt to obtain such consent but are unable to obtain such consent; or
- If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating with you, and we determine that, in or professional judgment, your consent to receive treatment is clearly inferred from the circumstances.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting in writing request to the Privacy Officer: Sonal Thakore

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternatives means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

Our policy is to require that all employees, past and present, keep all patient information confidential. Only employees who need access to patient records for business purposes will have it. Our privacy policy applies to both current and former patients.

This notice is effective as of October 1, 2002 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Sonal Thakore,
Privacy Officer -
Fairfield Dental Center
271 RT 46 West, D-108
Fairfield NJ 07004
Ph: (973) 227-1414

For more information about HIPPA or to file a complaint:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, D.C. 20201
(202) 619 - 0257
Toll Free – 1-877-696-6775