HERRICK FAMILY DENTISTRY

Susana Herrick, DMD | PHONE (860) 633-1809 | FAX (860) 633-6406
622 Hebron Ave., Suite 105, Glastonbury, CT, 06033

Patient Information (Confidential)

Name:______________________________ Date:______________
Address:__________________ City:__________ State:________ Zip:________
E-Mail:______________ Cell Phone:______________ Home Phone:______________
SS#/SIN:______________ Birth Date:______________
Check Appropriate: Minor:___ Single:___ Married:___ Divorced:___ Widowed:___ Separated:___
If College Student, FT__ / PT__, Name Of School:______________ City:__________ State:________
Patient's or Parent/Guardian's Employer: ______________Work Phone:______________
Business Address:__________________ City:__________ State:______ Zip:_______
Spouse or Guardians' Name:______________ Employer:__________ Work Phone:______________
Whom May We Thank For Referring You?______________________________
Person To Contact In Case Of Emergency:______________ Phone:______________

Responsible Party

Name of Person Responsible For This Account:______________ Relationship:______________
Address:__________________ Home Phone:______________
Driver's License #:______________ Birth Date:______________ SS#/SIN:______________
Employer:__________________ Work Phone:______________
Is This Person Currently A Patient In Our Office? Yes:_____ No:_____

Insurance Information

Name of Insured:______________ Relationship To Patient:______________
Birth Date:__________ SS#/SIN:__________ Date Employed:______________
Name of Employer:__________ Union Of Local#:________ Work Phone:______________
Employer Address:__________________ City:__________ State:___ Zip:________
Insurance Co.:__________ Tel#:__________ GRP#:__________ Policy/ID #:__________
INS Co. Address:______________ City:______________ State:_____ Zip:________
How Much Is Your Deductible?______ How Much Have You Used? _______ Max Annual Benefit:______

DO YOU HAVE ANY ADDITIONAL INSURANCE: **Yes: No:** ***If So Complete the Following:***

Name Of Insured:______________ Relationship to Patient:______________
Birth Date:__________ SS#/SIN:__________ Date Employed:______________
Name OF Employer:__________ Union of Local#:________ Work Phone:______________
Employer Address:__________________ City:__________ State:___ Zip:________
Insurance Co.:__________ Tel#:__________ GRP#:__________ Policy/ID #:__________
INS Co. Address:______________ City:______________ State:_____ Zip:________
How Much Is Your Deductible?______ How Much Have You Used? _______ Max Annual Benefit:______

X______________________________ ______________

SIGNATURE OF PATIENT/GUARDIAN IF MINOR. PATIENT NUMBER

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Patients Dental Health

Name:______________________________

Why have you come to see us today? (e.g. pain, checkup, etc.):______________________________

Previous dentist:______________ Last visit:______________ Date of last cleaning:______________

Reason for changing dentists:______________________________

Are you nervous about seeing a dentist? Yes:___ No:___ If yes, please tell us why? ______________

How often do you brush?:______________Do you floss? : Yes _____ No ______ How Often:______________

(please circle each)

Y N I clench or grind my teeth during the day or while sleeping

Y N My gums bleed while brushing or flossing

Y N I like my smile

Y N I prefer tooth-colored fillings

Y N I avoid brushing part of my mouth due to pain

Y N My gums feel tender or swollen

Y N I have problems eating

Y N I have had orthodontics

Y N I have had facial or jaw injury

Y N I want my teeth straight

Y N I want my teeth white

What are your dental priorities?

Patients Medical History

I consider my health to be (please check one) Excellent:____ Good:____ Fair:____ Poor:____

Do you or have you had any of the following? Please circle Y for yes or N for no.

1. Y N Heart Disease.
2. Y N Heart Murmur/Mitral Prolepses.
3. Y N Stroke.
4. Y N Congenital Heart lesions.
5. Y N Rheumatic Fever.
6. Y N Abnormal Blood Pressure.
7. Y N Anemia.
8. Y N Prolonged Bleeding Disorder.
9. Y N Tuberculosis or Lung Disorder.
10. Y N Asthma.
11. Y N Hay Fever.
12. Y N Sinus Trouble.
13. Y N Epilepsy/Seizures.
14. Y N Ulcers.
15. Y N Implants/Artificial Joints. Hip:___ Knee:___ Other:____
16. Y N I smoke or use Tobacco. If Yes. Per day:_____ How many Years:______
17. Y N I have consumed alcohol in the past 24 Hours.
18. Y N I usually take an antibiotic prior to dental treatment.
19. Y N Have you ever taken Fen-Phen or Redux?
20. Y N I have had major surgery: Year:______ Type or operation:______________
21. Y N Do you have any other medical problem or medical history NOT listed on this form?______________
22. Y N Liver Disease.
23. Y N Jaundice.
24. Y N Hepatitis Type_____
25. Y N Diabetes.
26. Y N Excessive Urination and /or thirst.
27. Y N Infectious Mononucleosis (mono)
28. Y N Herpes.
29. Y N Arthritis.
30. Y N STD's.
31. Y N Kidney Diseases.
32. Y N Tumor or Malignancy.
33. Y N Cancer/Chemotherapy.
34. Y N Radiation Treatment.
35. Y N History of drug Addiction.

Doctor Notes Only:

36. Y N AIDS
37. Y N Immune Suppressed Disorder.
38. Y N Hearing loss.
39. Y N Fainting Spells.
40. Y N Glaucoma.
41. Y N History of emotional or Nervous Disorders.

Women:

42. Y N Are you taking birth control Medication?
43. Y N Are you or could you be pregnant Or nursing?

Are you allergic to any of the following?
Please Circle Y for yes and N for No.

44. Y N Aspirin.
45. Y N Ibuprofen.
46. Y N Sulfa Drugs/Sulfates/Sulfides.
47. Y N Penicillin.
48. Y N Codeine.
49. Y N Latex, Metals, Plastics.
50. Y N Local Anesthetics. (Novocain).
51. Y N Other Medications – Which Ones?______________

Please list all medications you are currently taking:

Medicine: Condition:

Medicine: Condition:

Medicine: Condition:

Medicine: Condition:

Medicine: Condition:

Physician's Name:______________ Phone:______________

Address:______________ Fax:______________

In the event of an emergency please contact:

Name:______________ Relationship:______________ Phone:______________

Name:______________ Relationship:______________ Phone:______________

Initial medical/dental health reviewed by:

X______________ ___/___/___ X______________ ___/___/___

Doctor's Signature Date Patient's Signature Date

Periodic medical/dental health reviewed by:

X______________ ___/___/___ X______________ ___/___/___

Doctor's Signature Date If Patient is a minor: Parent/Guardian's Signature Date

HERRICK
FAMILY DENTISTRY

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OUR FINANCIAL POLICY

Thank you for choosing **Herrick Family Dentistry, P.C** as your dental care provider. We are committed to your treatment being successful. Please understand that the payment of your bill is considered to be a part of your treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, VISA, MASTERCARD, DISCOVER, AND CARECREDIT.

Regarding Insurance

We may accept assignment of insurance benefits. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare program and/or other dental insurance. Regarding insurance plans where we are a participating provider- All copays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where not participating providers, refer to the above paragraph.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advanced our policy is to charge for missed appointments at the rate of 29$ per appointment.

Interest and Overdue Balance

We reserve the right to charge interest in the amount of 1.5% per month as provided by the state law. If your account has an outstanding balance for more than 90 days, the account will be sent to an outside collection agency and a collection fee of $11.95 will be charged.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. Please sign below to acknowledge that you have read and agree to the Financial Policy.

X_________________________________ Date____________________

Signature of Patient or Responsible Party

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individuality 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.

We may use and disclose your medical records only for each of the following purposes:

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your 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 my also create and distribute de-identified health information by removing all references to individually identifiable information.

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 the 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 a written request to the Privacy Officer:

- 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 a 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 alternative 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 and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.
- The right to provide and we are obligated to receive a written acknowledgment that you have received a copy of or Notice of Privacy Practices.

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.

This notice is effective as of April 1, 2003 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 new 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 & 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.

For more information about HIPPA
Or to file a complaint:

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

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Notice of Privacy Practices Acknowledgment
Herrick Family Dentistry P.C.
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Suite 105
Glastonbury, CT 06033

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected 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 physicians' certifications

I acknowledge that I received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. 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 health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide to such restrictions.

Patient Name: ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date: ______________________________

Office Use only

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

Date	Initials	Reason