Colchester Dental Group
106 High Point Center Suite 100
Colchester, VT 05446

Date ____________

Patient Name ______________________________ Birthdate ____________ Age ____

Address ____

Social Security #____________________ Marital Status: __Single __Married __ Divorced __Widowed

Home Phone__________________________ Cell Phone__________________________

Occupation__________________________ Employer __________________________

Employer Name and Address____

Work Phone ____

Nearest Relative Not Living with You ______________________ Relationship____________

Phone Number for Relative ____

Person Responsible for Account__________________ __________Relationship____________

Insurance info:

Do you have Dental Insurance? __ Yes __ No Insurance Company__________________________

Insurance Company Address ____

ID# __________________________ Group # __________________________

____

Insurance Holders Name Sex Birthdate Social Security #

____

Spouse's Name Sex Birthdate Social Security #

Dental History:

Last visit to the Dentist ________________ For what Treatment ____________________

Previous Dentist Name__________________________ Date of most recent x-rays ___________

Chief Concern____

Are you fearful of dental treatment? Yes No

Have you had an unfavorable dental experience? Yes No

Have you ever had complications from past dental treatment? Yes No

Have you ever had trouble getting numb or had any reaction to local anesthetic? Yes No

Did you ever have braces, orthodontic treatment or had your bite adjusted? Yes No

Have you ever had teeth removed? Yes No

Do you ever notice an unpleasant taste or odor in your mouth? Yes No

Have you ever been treated for gum disease or been told you have bone loss around your teeth?Yes No

Is there anyone with history of periodontal disease in your family? Yes No

Have you had any teeth become loose on their own (without injury), or difficulty eating apples? Yes No

Have you experienced burning sensation in your mouth? Yes No

Do you have or have you ever noticed:

Hot/Cold/Sweet Sensitivity? Yes No
Pain when biting/chewing? Yes No
Ringing in your ears? Yes No
Tiredness after chewing? Yes No
Dry mouth? Yes No
Cavities in past 3 years? Yes No

Food traps in between your teeth? Yes No
Bleeding while brushing or flossing? Yes No
A clenching or grinding habit? Yes No
Irritated/Tender/Swollen gums? Yes No
Experienced gum recession? Yes No
Do you chew on both sides of mouth? Yes No

Do you feel or notice holes or pitting in the biting surface of your teeth? Yes No
Do you have grooves or notches on your teeth near the gum line? Yes No
Have you ever broken teeth, chipped teeth, had a toothache or cracked fillings? Yes No
Do you have problems with jaw pain? (pain, sounds, limited opening, locking or popping? Yes No
Do you feel like your lower jaw is being pushed back when you bite your teeth together? Yes No
Do you avoid or have difficulty chewing gum, hard or dry foods? Yes No
Have your teeth changed in the past 5 years, become shorter, thinner or worn? Yes No
Are your teeth crowding or developing spaces? Yes No
Do you have more than one bite and squeeze to make your teeth fit together? Yes No
Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? Yes No
Do you clench your teeth in the daytime or make them sore? Yes No
Do you have problems with sleep or waking up with an awareness of your teeth? Yes No
Do you have or have you ever worn a bite appliance? Yes No
Is there anything about the appearance of your teeth that you would like to change? Yes No
Have you ever whitened (bleached) your teeth? Yes No
Have you felt uncomfortable or self conscious about the appearance of your teeth? Yes No
Have you been disappointed with the appearance of previous dental work? Yes No

Medical History

Most recent Physical Examination______________Purpose________________________________
What is the name of your physician? ____

Do you have or have you ever had:

Hospitalization for illness or injury? ______________________________________ Yes No
An allergic reaction to

- __ Aspirin, ibuprofen, acetaminophen, codeine
- __Penicillin
- __Erythromycin
- __Tetracycline
- __Sulfa
- __Local anesthetic
- __Fluoride
- __Metals (Nickel, gold, silver___________)
- __Latex
- __Other____________________________

Are you:

Presently being treated for any other illness ______________________________ Yes No
Aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) Yes No
Taking medication for weight management (i.e. fen-phen) ______________________ Yes No
Taking dietary supplements ______________________________________ Yes No
Often exhausted or fatigued ______________________________________ Yes No
Experiencing frequent headaches ___________________________________ Yes No
A smoker, smoked previously our use smokeless tobacco _______________________ Yes No
Often unhappy or depressed ______________________________________ Yes No
Female- Taking birth control ______________________________________ Yes No
Female- Pregnant ____ Yes No
Male- Prostate disorders ____ yes No

Describe any current medical treatment, impending surgery, genetic/ development delay, or other treatments that may possibly affect your dental treatment. (i.e. Botox, Collagen injections)

List all medications, supplements, and or vitamins taken within the last two years ______________

____

I ______________________________, have received and understand the Colchester Dental Group Policy regarding Dental Insurance, in addition I authorize the release of any information related to my dental insurance claim, I authorize payment directly from my insurance company to Colchester Dental Group and understand that I am responsible for all fees not paid by insurance.

____
Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices: (HIPPA)

I______________________ have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name Signature Date

Please advise us in the future of any changes in your medical history or any medications you may take.

Heart problems, or cardiac stent within the last six months ______ Yes No
History of infective endocarditis ______ Yes No
Artificial heart valve, repaired heart defect (PFO) ______ Yes No
Rheumatic or scarlet fever ______ Yes No
High or low blood pressure ______ Yes No
A stroke (taking thinners) ______ Yes No
Anemia or other blood disorder ______ Yes No
Prolonged bleeding due to a slight cut (INR>3.5) ______ Yes No
Emphysema, shortness of breath, sarcoidosis ______ Yes No
Tuberculosis, measles, chicken pox ______ Yes No
Asthma ______ Yes No
Breathing or sleeping problems (i.e. sleep apnea, snoring, sinus) ______ Yes No
Kidney disease ______ Yes No
Liver disease or Jaundice ______ Yes No
Thyroid, parathyroid disease, or calcium deficiency ______ Yes No
Hormone deficiency ______ Yes No
High cholesterol or taking statin drugs ______ Yes No
Diabetes (HbA1c=______) (Type) ______ Yes No
Stomach or duodenal ulcer ______ Yes No
Digestive disorders (i.e. celiac disease, gastric reflux) ______ Yes No
Osteoporosis/ osteopenia (i.e. taking bisphosphonates ______ Yes No
Arthritis, rheumatoid arthritis, lupus ______ Yes No
Glaucoma ______ Yes No
Head or neck injuries (concussion & or TBI) ______ Yes No
Epilepsy, convulsions (seizures) ______ Yes No
Neurologic disorders (ADD/ ADHD, prion disease) ______ Yes No
Viral infections and cold sores ______ Yes No
Any lumps or swelling in your mouth ______ Yes No
Hives, skin rash, hay fever ______ Yes No
STI/ STD ______ Yes No
Hepatitis (type______) ______ Yes No
HIV/ AIDS ______ yes No
Tumor, abnormal, growth ______ yes No
Radiation therapy ______ Yes No
Chemotherapy, immunosuppressive ______ Yes No
Emotional problems/ Anxiety ______ Yes No
Psychiatric treatment ______ Yes No
Antidepressant medication ______ Yes No
Alcohol/ street drugs ______ Yes No
Joint replacement (knee, hip,ext) ______ Yes No
Pre-medicate with antibiotics before dental appointments ______ Yes No

Colchester Dental Group

106 Highpoint Center Suite 100

Colchester, VT 05446

Our Policy Regarding Dental Insurance

Whether you have purchased dental insurance on your own or your employer has provided it for you, you are fortunate to have it and we will go the extra mile to help maximize the benefits provided by your specific plan. We understand filing insurance claims can be time consuming and confusing, so as a courtesy to you, we will file your primary insurance form for you; we do not, however, file for secondary insurances.

Insurance companies usually only pay a percentage of the fee and vary from plan to plan. Your dental insurance is not designed to pay for the entire cost of treatment, but is intended to help cover a certain portion of the cost. A better term may be *"dental assistance."* Please be aware that some insurance companies state *"100%" "80%" "50%"* etc. coverage which can be misleading as that refers to the percentage they will cover according to their internal, pre-determined rates which are often years old, not the current fair market rates. The percentage coverage safely applies only if we are in network with your insurance company.

Please understand the financial obligation for treatment is between you and this office, not between our office and the insurance company and any remaining balance is your responsibility. It is ultimately your responsibility to become familiar with your insurance plan and any clauses it may have in it.

For your safety, this office only uses resin fillings (tooth colored) as amalgam (silver colored) fillings are made of heavy metals and studies show that heavy metals such as mercury in your teeth and bloodstream can be harmful over time.

On rare occasions, a dental insurance plan will require a "pre-determination" also known as "prior authorization" for treatment. If they do, we will be happy to submit a treatment plan to your insurance company upon request. In order for us to submit your form, we ask that you provide the following:

- A copy of your insurance booklet or a copy of your insurance card

- A copy of a signed insurance form with the date of birth of the subscriber, SSN, alternate ID number, group of ID number and the name of the employee, whichever is applicable.

The best way to get specific information regarding your policy is to call the insurance company directly.

Please keep this for your personal records

Colchester Dental Group
106 High Point Ctr., Suite 100
Colchester, VT 05446
(802) 655-5308 (802) 655-5715

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 4/14/03, 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.