Fairfield Family Dentistry

1817 Black Rock Tpke, Suite 207, Fairfield, CT, 06825

PATIENT INFORMATION…PLEASE PRINT

Last Name: ______________________________ **First Name:**______________________________

Mailing Address: ____

City: __________________________ **State:** __________ **Zip Code:** _________________

Marital Status: **M** **S** **D** **W** **Date of Birth:** ____/_____/______

Home Phone: _______________________ **Work Phone:** ________________________

Cell Phone: _______________________ **Email:** __________________________

Preferred Method of Contact: **Text** **Email** **Phone Call**

Emergency Contact: Name: ____

Phone Number: _________________________ Relationship to Patient: _________________

PARENT/GUARDIAN (if a minor) or SPOUSE INFORMATION

Parent/Spouse Name: _________________________ Date of Birth: ______/_______/_______

Address: ____

Employer: ____________________________________

DENTAL INSURANCE INFORMATION

Primary Insurance: _________________________ Subscriber: ______________________

Insurance is through: Self Spouse Mother Father Guardian Employer: _______________

Subscriber ID Number: _________________________________

Secondary Insurance: ______________________ Subscriber: _______________________

Insurance is through: Self Spouse Mother Father Guardian Employer: _______________

Subscriber ID Number: _________________________________

How did you hear about our office? Phone Book Internet Search Insurance Company

Facebook Patient _______________________

Fairfield Family Dentistry

1817 Black Rock Tpke, Suite 207, Fairfield, CT, 06825

MEDICAL INFORMATION

Please circle any of the following which you have had or have currently:

Alcohol or Drug abuse	**Diabetes**	**Latex Allergy**
Anemia or Hemophilia	**Epilepsy or Seizures**	**Positive HIV Test or AIDS**
Arthritis	**Fainting or dizzy spells**	**Radiation Therapy**
Artificial Heart Valve/Joints	**Heart Murmur**	**Respiratory/Lung Disease**
Asthma	**Heart Problems**	**Rheumatic Fever**
Cancer or Tumor	**Hepatitis or Liver Disease**	**Sinus problems**
Chemotherapy	**High Blood Pressure**	**Surgery**
Cold Sores	**Kidney Disease**	**Thyroid Disease**

Other medical conditions (not listed above): ____

____

Have you been under the care of a medical doctor during the past two years? **Yes** **No**

If yes, for what reason? ____

Medical Doctor's Name and Phone Number: ____

Are you currently taking any prescription or over-the-counter drugs: **Yes** **No** If yes, list below:

____

____

____

Are you allergic to any medication(s)? ____

Have you ever been told you need to be pre-medicated prior to dental treatment? YES NO

Women: Are you pregnant or nursing: YES NO

Are you taking birth control medication? Yes No

Fairfield Family Dentistry

1817 Black Rock Tpke, Suite 207, Fairfield, CT, 06825

DENTAL INFORMATION

We strive to provide optimal oral health to our patients. Please complete the dental survey to the best of your knowledge to help us get to know you and your oral health.

Previous Dentist: ____

When was your last dental visit? ______________________________________

What was the reason? ____

Are you currently experiencing any dental problems? Yes/No ____________________

Do your gums bleed when you brush? Yes No

Do your gums bleed when you floss? Yes No

Are you nervous to have dental treatment? Yes No

Have you had a bad dental experience in the past? Yes No

What would you change about your smile?

Replace missing teeth Yes No

Bad breath Yes No

Gum disease Yes No

Appearance of smile Yes No

Straighter teeth Yes No

Whiter teeth Yes No

Other: ______________________________________

The information above is accurate and completed to the best of my knowledge. I agree to inform the team of Fairfield Family Dentistry, LLC of any changes in my medical condition. I also agree that no employee at Fairfield Family Dentistry, LLC shall be held responsible for any error or omission that I may have made in the completion of my medical and dental information.

Signature: ______________________________ **Date:** ____________________

Fairfield Family Dentistry

1817 Black Rock Tpke, Suite 207, Fairfield, CT, 06825

HIPAA Consent Form

Name: ____

Address: ____

Date of Birth: _____/______/_______

CONSENT & NOTICE OF PRIVACY PRACTICES Please read the following statements carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operation.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting us by phone or email.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance of this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

☐ I have had full opportunity to read and consider the contents of this Consent & Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations

Name of Patient/Legal Guardian: ____

Signature of Patient/Legal Guardian: ____________________________________ **Date:** ____________