Bristol Dental Associates

PATIENT'S NAME ___________________ ________________ _____ ☐ male ☐ female ____/____/____
Last First Initial Date of Birth

NOTE: PLEASE CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

1. Physician's Name ________________________________
   Address ____
2. Are you under a physician's care? ______________________ YES NO
   Since when_________________Why________________________
3. When was your last complete physical exam? __________________
4. Are you taking any medication or substances? ____________________ YES NO
   (If yes, please list medications in the box at the bottom of this form.)
5. Do you routinely take health related substances? ___________________ YES NO
6. Are you allergic to any medications or substances?__________________ YES NO
7. Do you have any other allergies? ___________________________ YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? __________________ YES NO
9. Are you sensitive to any metals or latex? ______________________ YES NO
10. Do you currently have any dental pain or swelling? __________________ YES NO
11. Do you currently have any open sores or lesions in or around you mouth? YES NO
12. Have you seen any other dentist, doctor or specialist for any dental problems relating to any issues you currently have or have had? YES NO
    If so who and when: ________________________________
13. Are you pregnant or suspect you may be? ______________________ YES NO
14. Do you use any birth control medications? _____________________ YES NO
15 Have you ever been treated for or been told you might have heart disease? YES NO
16. Do you have a pacemaker or heart valve implant? __________________ YES NO
17. Have you ever had rheumatic fever? __________________________ YES NO
18. Are you aware of any heart murmurs? _________________________ YES NO
19. Do you have high or low blood pressure? _______________________ YES NO
20. Have you ever had a serious illness or major surgery? YES NO
    If so, explain_______________________________________
21. Have you ever had radiation treatment, chemo treatment for a tumor, growth or other condition? ______________________________ YES NO
22. Do you have inflammatory diseases, such as arthritis or rheumatism? ______ YES NO
23. Do you have any artificial joints/prosthesis? ____________________ YES NO
24. Do you have any blood disorders, such as anemia, leukemia, etc? _________ YES NO
25. Have you ever bled excessively after being cut or injured? ______________ YES NO
26. Do you have any stomach problems? __________________________ YES NO
27. Do you have any kidney problems? ___________________________ YES NO
28. Do you have any liver problems? ____________________________ YES NO
29. Are you diabetic? _____________________________________ YES NO
30. Do you have asthma? ___________________________________ YES NO
31. Do you have epilepsy or seizure disorders? _____________________ YES NO
32. Do you or have you had venereal disease? ______________________ YES NO
33. Have you tested HIV positive? ______________________________ YES NO
34. Do you have AIDS? ____________________________________ YES NO
35. Have you had or do you test positive for hepatitis? __________________ YES NO
36. Do you or have you had T.B.? ______________________________ YES NO
37. Do you smoke, chew, use snuff or any other forms of tobacco? ____________ YES NO
38. Do you consume alcoholic beverages? _________________________ YES NO
39. Are you in good health? __________________________________ YES NO
40. Do you habitually use controlled substances? ____________________ YES NO
41. Do you have any disease, condition, or problem not listed? If so, explain
    ____
    ____
42. Is there anything else we should know about your health that we have not covered in this form?
    ____
43. Would you like to speak to the Doctor privately about any problem? YES NO

Doctor Comments

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENTS/GUARDIAN'S SIGNATURE___________________________DATE ___/___/___

DENTIST'S SIGNATURE ___________________________ DATE ____/____/____

Current Medications

____

____

____

Bristol Dental Associates

PATIENT'S NAME ____ ☐ male ☐ female ____/____/____ Date of Birth
Last First initial

Parent/Guardian Name:

____

COMMENTS:

DENTAL HISTORY - CIRCLE THE APPROPRIATE ANSWER

1. Is this your child's first visit to a dentist? YES NO
2. If not, how long since the last visit to the dentist: ________________________
3. Were any x-rays or radiographs taken when your child previously visited the dentist? YES NO
4. Does your child eat between meals? YES NO
5. Does your child eat sweets, such as candy, soda pop, chewing gum? YES NO
6. When does your child brush his/her teeth?
   Upon arising After eating any food Right after meals Before going to bed
7. Does your child receive Fluoride?
   Community water, level ___ ppm Well water, level ___ ppm
   Fluoride drops or tablets Fluoride rinse or gel
8. Have any cavities been noted in the past? YES NO
9. Were any teeth (baby or permanent) removed by extraction? YES NO
   Was it suggested that the space be maintained? YES NO
   Was an appliance placed? YES NO
10. Have there been any injuries to teeth, such as falls, blows, chips, etc.? YES NO
    If so, please describe____
11. Has your child had any problem with dental treatment in the past? YES NO
12. Has anyone in the family, including parents, had orthodontics? YES NO
13. Has your child ever received a local anesthetic? YES NO
14. Has your child ever had occlusal sealants? YES NO
15. Does your child think there is anything wrong with his/her teeth? YES NO

MEDICAL HISTORY - CIRCLE THE APPROPRIATE ANSWER

1. Does your child have a health problem? YES NO
2. Is your child under the care of a physician? YES NO
3. Name of physician Phone
   ____
4. Is your child receiving any medication? YES NO
5. Is your child allergic to penicillin, antibiotics or other drugs? YES NO
6. Is your child allergic to or sensitive to any metals or latex? YES NO
7. Has your child had any serious illness? YES NO
   When________________________ What ____________________________
8. Has your child ever had surgery? YES NO
9. Does your child have a heart murmur? YES NO
10. Is surgery contemplated? YES NO
11. Does your child experience severe or prolonged bleeding? YES NO
12. Does your child have AIDS or has he/she tested HIV positive? YES NO
13. Has your child tested positive for hepatitis? YES NO
14. Is your child subject to nervous disorders? YES NO
    Fainting Seizures? Dizziness? Behavior/Learning problems?
15. Does your child have frequent headaches? YES NO
16. Has your child had a history of (Circle appropriate responses,) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

Current Medications

____
____
____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PARENT/GUARDIAN SIGNATURE____ DATE ____________

DENTIST SIGNATURE ____ DATE ____________

CHILD DENTAL MEDICAL HISTORY

STACY N. BUTLER, D.D.S.

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 04/14/2003, 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 effect any 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 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 toe 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.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcard, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably to do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $_______ for each page, $_______ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-mmonth period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about your access to your health information or in response to a request you made to amend or restrict that use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your Health information. We will not retaliate in any way if you choose file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Tiffany H.

Telephone: (860) 589-3529 Fax: (860) 589-7546

Address: 1235 Farmington Avenue #9 Bristol, CT 06010

E-mail: sbutlerdds@att.net

STACY N. BUTLER, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgement****

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
{Please Print Name}

____
{Signature}

____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

____
____
____
____

STACY N. BUTLER, D.D.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____

Address: ____

SECTION B: TO THE PATIENT --- 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 operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decided 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. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

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:

Contact Person: Tiffany H.

Telephone: (860) 589-3529 Fax #: (860) 589-7546

Address: 1235 Farmington Avenue #9 Bristol, CT 06010

Email: sbutlerdds@att.net

Right to Revoke: You will have the right to revoke this Consent at any time by giving us 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 on 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.

SIGNATURE:

I, ____, have had full opportunity to read and consider the contents of this Consent form and your 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.

I also authorize my dental information to be released to the following recipient(s):

____

Signature: ____ Date: ________________________

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____

Stacy N. Butler, DDS LLC
Bristol Dental Associates

Welcome to our office, we sincerely appreciate you choosing us for your dental health needs. We're here to serve and care for you. Your best interests are our chief concern.

Patient Information

Name (Last, First, Middle): ______________________________ Preferred Name: ________________

Address: ________________________City: ________________State: ________ Zip Code:________

Date of Birth: ____________ Sex: M ___ F ___ Marital Status: __________

Social Security Number: _____/_____/_____ Driver License Number: ________________

Home Phone: ______________ Work Phone: ______________ Ext: ______

Cell Phone: ________________ Employer: __________________ Email: ____________________

Preferred Contact Number: ____________________ Referred By: ____________________

Emergency Contact: ____________________ Contact Phone Number: ________________________

Primary Dental Insurance Coverage

Subscriber Name: ________________________________ Relationship to Patient: ________________

Address: ____

Social Security Number: _____/_____/_____ Employer: ________________________________

Date of Birth: ______________ Employer Address: ________________________________

Insurance ID#: ______________ Group #: ____________

Insurance Company: _____________ Insurance Address: ________________________________

Secondary Dental Insurance Coverage

Subscriber Name: ________________________________ Relationship to Patient: ________________

Address: ____

Social Security Number: _____/_____/_____ Employer: ________________________________

Date of Birth: ______________ Employer Address: ________________________________

Insurance ID#: ______________ Group #: ____________

Insurance Company: _____________ Insurance Address: ________________________________

Medical Insurance Coverage

Subscriber Name: ________________________________ Relationship to Patient: ________________

Plan Name: ______________________ Group Number: ________________

Responsible Party

I understand that payment for services is due and payable at the time of service and is my responsibility, unpaid balances will accrue interest at the rate of **1 ½% per month (18% per annum).** I also understand that my dental insurance is a contract between me and my insurance carrier. I further agree to pay any and all costs of collection, legal or other fees required should I fail to meet my financial obligations in a timely manner. I authorize Bristol Dental Associates to send me postcards with appointment information and leave me telephone messages regarding same and any copays due from me at my home or work. I also, by my signature below, authorize Bristol Dental Associates and its employees or agents to release/discuss any dental or medical information necessary to institute or enable processing of a claim of any nature to any insurance company or course of treatment with specialist or other health care providers and also authorize payment directly to Bristol Dental Associates or its designees. **There will be a processing fee of $25.00 on any checks returned. We reserve the right to charge $65.00 for appointments cancelled or broken without 24 hours advance notice.**

Signature: ______________________________________ Date: ____________________________