NORTH MAIN DENTAL
Jeanne P. Strathearn, DDS
12 North Main Street, Suite 101
West Hartford, CT 06107
860-236-4249

Patient Information

Name _____ Date _____
First Middle Last

What do you preferred to be called? _____

Address_____City_____ State_____ Zip_____

Cell #_____ Home phone_____Soc. Security #_____ Birthdate_____

Email_____ Remind me of my appointments by ☐ **Email only** ☐ **phone only**?
☐ **Email AND phone**

Check Appropriate Box ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐ Separated

If college student, F.T/P.T., name of school _____City_____ State_____

Spouse or parent's name_____

Whom may we thank for referring you? _____

Person to contact in case of an emergency_____ Phone_____

FULL PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED. If you have questions on your suggested treatment plan or the choice of payment options, please do not hesitate to ask. We are here to help you get the dentistry you want and need.

Insurance Information

Name of insured_____ Relationship to patient_____

Birthdate _____ Soc. Security # _____

Name of employer _____Union or local # _____Work phone_____

Employer address _____City _____State_____ Zip_____

Insurance Co._____ Grp. #_____Policy/I.D.#_____

Do you have any additional dental insurance ☐Yes ☐No If yes, complete the following:

Name of insured_____ Soc. Security #_____

Name of employer_____ Union or local # _____Work phone _____

Employer address _____City _____State_____ Zip_____

Insurance Co._____ Grp. #_____ Policy/I.D. #_____

Ins. Co. address_____ City_____ State_____ Zip_____

X _____
Signature of patient (or parent, if minor)

01/2012

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

General Consent for Dental Treatment by: Dr. Jeanne P. Strathearn, DDS, 12 North Main Street, West Hartford, CT

I voluntarily request Dr. Jeanne P. Strathearn, and her technical assistants to provide dental and oral hygiene services, as Dr. Strathearn deems advisable. I understand that I will receive an oral examination and may have some x-rays and other diagnostic tests. Dr. Strathearn may discover or diagnose oral or dental conditions that may require additional treatments and procedures. Dr. Strathearn or the dental hygienist may clean and scale my teeth both for the purposes of diagnosis and treatment, and for the maintenance of good oral hygiene.

I understand that certain treatments and procedures may cause discomfort. I consent to the use of topical and injected local anesthetic agents in connection with some dental procedures and treatments. I might experience numbness and/or tingling after the use of these anesthetic agents. Anesthetic agents may have side effects and may cause additional risks and hazards.

I understand that certain treatments and procedures may involve the use of chemical substances and the administration of medicines, both prescription and non-prescription. These substances and medicines may have unpleasant or unusual tastes or may have side effects. Certain treatments and procedures, especially those involving surgery, may disturb or injure tissues and cause local bleeding. I may experience swelling, bruising, stiffness and tenderness. Infection is unlikely, but may occur.

Dr. Strathearn may suggest or recommend that I perform dental and hygiene care at home or that I consult with a specialist. This care is important to my dental health and may affect the outcome of any treatment or procedures that are provided in this office. Regularly scheduled dental care is important to my dental health and to the effectiveness and success of provided treatment and procedures. I understand that dentistry is not an exact science and that there are no guarantees or warranties about the effectiveness or results of treatment.

I have given Dr. Strathearn a complete medical history. I have disclosed any medical conditions that may cause complications including sensitivities, allergies, pregnancy, HIV, clotting disorders, medications that affect clotting, hepatitis, and heart or circulatory conditions. I can ask Dr. Strathearn questions at any time regarding diagnosis, procedures and treatment. If I do experience any side effects or complications during or after treatment, I will tell Dr. Strathearn immediately.

I certify that I have read this form and/or it has been fully explained to me and that I fully understand its contents. I certify that I have had the opportunity to ask questions about the contents of this form and I believe that I have enough information to make this informed consent.

Patient Signature:_____ Date:_____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 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 have received, read and understand 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 treatments, payment or health care operations. I also understand you are not required to agree to my requested retractions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

Office Use Only:

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

Date: _____ Initials: _____ Reason: _____

CANCELLATION POLICY NOTIFICATION

PLEASE NOTE THE FOLLOWING:

Please call our office at 860-236-4249 as soon as possible if you are unable to keep your scheduled appointment. We ask that you give us a minimum of 24 hours notice prior to the appointment time with changes and cancellations. Please call our office between the hours of 8:00 a.m. and 4:30 p.m. for assistance. If you call us after hours, please leave a message on our answering machine. Message will be returned the following day.

FAILURE TO PROVIDE US WITH A 24-HOUR NOTICE OF AN APPOINTMENT CHANGE OR CANCELLATION MAY RESULT IN A CHARGE OR DISMISSAL FROM OUR OFFICE.

_____ DATE: _____
Signature

PRINT NAME:
_____