Dr. Luciana Rausch, D.M.D.
1336 West Main St, Suite 2B
Waterbury, CT 06708
Telephone: (203) 754-4175

PATIENT INFORMATION AND HEALTH HISTORY

INITIAL EXAM DATE_____

PATIENT'S NAME_____

DATE OF BIRTH_____ PHONE _____

PATIENT'S ADDRESS_____

TOWN / CITY_____ STATE_____ ZIP CODE _____

PERSON RESPONSIBLE FOR THIS ACCOUNT_____ PHONE_____

DENTAL HISTORY

CHIEF ORAL COMPLAINT_____

DATE OF LAST DENTAL EXAM_____ ANY PREVIOUS MAJOR DENTAL TREATMENT ☐ YES ☐ NO

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING – INDICATE WITH A (√)

- ☐ Teeth sensitive to cold, heat, sweets or pressure
- ☐ Bleeding gums. How long_____
- ☐ Food Impaction
- ☐ Clenching or grinding
- ☐ Burning of tongue
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain around ear
- ☐ Unusual sounds in ear while eating
- ☐ Bad breath
- ☐ Unpleasant taste
- ☐ Unfavorable dental experience
- ☐ Complications from extractions
- ☐ Periodontal treatment
- ☐ Orthodontic treatment
- ☐ Mouth breathing
- ☐ Oral habits, i.e., fingernail biting, cheek biting…
- ☐ Cigarettes, pipe or cigar smoking
- ☐ Texture of toothbrush_____
- ☐ Frequency of brushing_____
- ☐ Dental floss
- ☐ Interdental stimulators
- ☐ Water jet device
- ☐ Disclosing tablets or solution
- ☐ Fluoride supplements
- ☐ Alcohol

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MEDICAL HISTORY

PHYSICIAN'S NAME_____ DATE OF LAST PHYSICAL EXAM_____

DO YOU HAVE OR DO HAVE YOU HAD ANY OF THE FOLLOWING – INDICATE WITH A (√)

- ☐ Allergies to drugs
- ☐ Allergies to anesthetics
- ☐ Any heart ailments
- ☐ High blood pressure
- ☐ Neurological problems
- ☐ Radiation treatments
- ☐ Excessive bleeding from cut or extraction
- ☐ Anemia or blood problems
- ☐ Arthritis
- ☐ Chronic Fatigue Syndrome
- ☐ Asthma
- ☐ Hay fever or allergies in general
- ☐ Diabetes
- ☐ Kidney problems
- ☐ Latex sensitivity
- ☐ Liver problems or hepatitis
- ☐ Malignancies
- ☐ Psychiatric care/emotional problems
- ☐ Rheumatic fever
- ☐ Sinus problems
- ☐ Immune System Disorders (AIDS, HIV, ARC)
- ☐ Stroke
- ☐ Thyroid
- ☐ Eye disorders
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer or colitis
- ☐ Pregnancy. If so, what month_____
- ☐ Venereal disease
- ☐ Other _____

Describe any current medical treatment including drugs taken, even though not listed above_____

_____

_____

INSURANCE: To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

SIGNATURE_____DATE_____
(PARENT OR GUARDIAN, IF PATIENT IS A MINOR)

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DENTAL INSURANCE INFORMATION

NAME OF INSURED_____

INSURED'S BIRTH DATE_____ ID # OR SSN_____ GROUP #_____

INSURED'S ADDRESS_____

TOWN / CITY_____ STATE_____ ZIP CODE _____

INSURED'S EMPLOYER NAME_____

EMPLOYER'S ADDRESS_____

TOWN / CITY_____ STATE_____ ZIP CODE _____

PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER_____

INSURANCE PLAN NAME_____

INSURANCE ADDRESS_____

TOWN / CITY_____ STATE_____ ZIP CODE _____

_____

PLEASE FILL OUT THE FOLLOWING INFORMATION ONLY IF YOU HAVE A SECONDARY DENTAL INSURANCE:

SECONDARY DENTAL INSURANCE

NAME OF INSURED_____

INSURED'S BIRTH DATE_____ ID # OR SSN_____ GROUP #_____

INSURED'S ADDRESS_____

TOWN / CITY_____ STATE_____ ZIP CODE _____

INSURED'S EMPLOYER NAME_____

EMPLOYER'S ADDRESS_____

TOWN / CITY_____ STATE_____ ZIP CODE _____

PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER_____

INSURANCE PLAN NAME_____

INSURANCE ADDRESS_____

TOWN / CITY_____ STATE_____ ZIP CODE _____

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HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out treatment, payment and healthcare operations.

- Treatment including direct or indirect treatment by other healthcare providers involved in my case.
- Payment: we may use and disclose your health information to obtain payment for services we provide to you.
- The day-to-day healthcare operations of our practice in relation to your treatment.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice periodically and that I may contact you at any time to obtain the most current copy 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.

I understand that I have the right to request restriction on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, then you are bound to comply with this restriction.

I understand that I may revoke this consent in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signature_____

Printed Name_____ Date_____

(Relationship to patient) _____

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CONSENT FOR INTERNET COMMUNICATIONS

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured website for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any changes, damages or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password or my authorization to allow another person or entity to access and use the dental practice website with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance and storage of my information and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the website on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the website for the dental practice, and grant the dental practice permission to securely upload my patient information to the website.

SIGNATURE_____ DATE_____
(PARENT OR GUARDIAN, IF PATIENT IS A MINOR)

(Relationship to patient) _____

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CONSENT FOR SERVICES

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credits any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee to telephone me to discuss this statement or my treatment.

I have read the above conditions of treatment and payment and agree to their content.

SIGNATURE_____ DATE_____

(PARENT OR GUARDIAN, IF PATIENT IS A MINOR)

(Relationship to patient) _____

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CANCELLATION POLICY

Dear patient,

We are committed to meeting our patients dental care needs. “No-shows” and late cancellations waste precious time that other patients could use and they should not be asked to subsidize your broken appointments through higher fees than necessary. In an effort to reduce the number of such occurrences, we have the following cancellation policy.

Please, be advised that:

- **All appointments** must be **cancelled** with a **24 hours notice** to avoid charges for a “no-show” or late cancellation;
- A “no-show” / late **cancellation fee of $50.00 per half hour** of appointment time will be charged into your account;
- If you are late for an appointment, you will be seen as soon as possible, at our staff’s convenience, though the office visit may need to be shortened in length;
- Our office makes reminder calls for appointments. However, it is ultimately the patient’s responsibility to remember their scheduled appointments.

Please note that your insurance will not cover charges for a “no-show” / late cancellation fee; therefore, you, as a patient, are directly responsible for the payment and would not be able to schedule future appointments until the fee is paid in full. The balance is expected in a timely fashion and if not, will be subject to collections.

If you have any questions regarding billing, please call our office at (203) 754-4175 during our regular business hours.

We thank you for trusting our office with your dental care!

I have read the document and understand that I will be financially responsible for all missed scheduled appointments that are not cancelled as described in the policy above.

Signature_____

Printed Name_____ Date_____