Advanced Family Dentistry of Old Lyme
MICHAEL D'OCCHIO, DMD
6 DAVIS ROAD WEST - OLD LYME, CT 06371 PHONE: 860.434.5565 FAX: 860.434.5880

WWW.ADVANCEDFAMILYDENTISTRYOFOLDLYME.COM
MICHAELDOCCHIODMD@GMAIL.COM

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Patient is: ☐ Responsible Party ☐ Policy Holder

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date: _____ Social Security #: _____ E-mail: _____

Emergency Contact: _____ Phone Number: _____ Relation: _____

Dental History

What is the reason for your visit today? _____

Previous Dentist's Name: _____

Phone Number: _____ State: _____

Date of Last Dental Cleaning: _____ Last Full Mouth x-rays _____

Responsible Party/Primary Insurance Information:

Name of Insured: _____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Secondary Insurance Information:

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

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CONSENT FOR TREATMENT

I hereby authorize Doctor or designated staff to take dental x-ray's, photographs, impressions and other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of my dental needs.

Upon such diagnosis, I authorize Doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedative and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks and I understand that I can ask for a complete list of any possible complications.

I give consent to the Doctor or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available if requested.

Patient, Parent or Guardian's Signature _____

Print Patient's Name _____

Relationship to Patient (if guardian) _____

Date _____

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PATIENT HIPPA 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 Information Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you, Advanced Family Dentistry of Old Lyme, to use and disclose my protected health information to carry out the following:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payer (e.g. My insurance company);
- The day-to-day healthcare operations of Advanced Family Dentistry of Old Lyme's healthcare practice

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operation, and that you are then 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.

Patient, Parent or Guardian's Signature _____

Print Patient's Name _____

Relationship to Patient (if guardian) _____

Date _____

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WRITTEN FINANCIAL POLICY

Thank you for choosing Advanced Family Dentistry of Old Lyme. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

-Cash, Check, Visa, Mastercard, American Express or Discover Card

-Convenient Monthly Payment Options from CareCredit Healthcare Credit Card which A.) Allows you to pay over time, and B.) No annual fees or pre-payment penalties

Please note:

Advanced Family Dentistry of Old Lyme requires payment upon the completion of your treatment.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.

A fee of $50 is charged for patients who miss or cancel without 24-hour notice.

Advanced Family Dentistry of Old Lyme charges $35 for returned checks.

Patient, Parent or Guardian's Signature _____

Print Patient's Name _____

Relationship to Patient (if guardian) _____

Date _____

Eaglesoft Medical History(Copy)

Patient Name: Birth Date: Date Created:

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.

Have you ever been hospitalized or had a major operation in the last 5 years ?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs? Please list.	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco, tobacco products?	◯ Yes ◯ No	
Name of medical doctor?		
Last time you saw your medical Doctor?		

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other Allergies -	◯ Yes ◯ No	If yes
Do you use controlled substances ?	☐	If yes

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	Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No
Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No
High Cholesterol	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No
Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No
Tonsillitis	◯ Yes ◯ No	Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ 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	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No

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

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:

X Date:_____