Cappello Family Dental
105 Technology Drive, Suite G2
Trumbull, CT 06611

Patient Information

Name:_____ Date:_____

□ Male □ Female □ Married □ Single □ Child □ Other _____

Birth Date: _____

Phone (Home): _____(Work): _____(Cell): _____

Email address_____

Address: _____

Street Apartment #

_____

City State Zip Code

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check all that apply:

□ AIDS
□Allergies _____
□ Anemia
□ Arthritis
□ Artificial Joints
□ Asthma
□ Blood Disease
□ Cancer
□ Diabetes
□ Dizziness
□ Epilepsy
□ Excessive Bleeding
□ Fainting
□ Glaucoma
□ Growths
□ Hay Fever
□ Head Injuries
□ Heart Disease
□ Heart Murmur
□ Hepatitis
□ High Blood Pressure
□ Jaundice
□ Kidney Disease
□ Liver Disease
□ Mental Disorders
□ Nervous Disorders
□ Pacemaker
□ **Pregnancy** Due Date: _____
□ Radiation Treatment
□ Respiratory Problems
□ Rheumatic Fever
□ Rheumatism
□ Sinus Problems
□ Stomach Problems
□ Stroke
□ Tuberculosis
□ Tumors
□ Ulcers
□ Venereal Disease
□ Codeine Allergy
□ Penicillin Allergy
OTHER:
□ _____
□ _____

- Have you ever had any complications following dental treatment? □ Yes □ No

If yes, please explain: _____

- Have you been admitted to a hospital or needed emergency care during the past two years? □ Yes □ No

If yes, please explain: _____

- Are you now under the care of a physician? □ Yes □ No

If yes, please explain: _____

- Name of physician:_____ Phone: _____
- Do you have any health problems that need further clarification? □ Yes □ No

If yes, please explain: _____

_____

_____

Please list any medications you are currently taking:_____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice?

☐Another patient, friend ☐Another patient, relative ☐Dental Office ☐Yellow pages ☐Newspaper ☐School ☐Work

☐Insurance Company ☐Other _____

Name of person or office referring you to our practice: _____

Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the patient's parent ☐ the patient's legal guardian ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____(Work): _____(Cell): _____

Address: _____

Street apartment #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address _____

Insurance Information

Primary

Name of Insured:_____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #:_____ Group #:_____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured:_____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #:_____ Group #:_____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

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Notice of Privacy Practice Acknowledgement

I understand that under the Health Insurance Portability Act of 1998 (HIPPA). I have certain rights to privacy regarding my protected Health information. I understand that this information can and will be used to:

-Conduct plans and direct my treatment and follow up among the multiple Healthcare Provides 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 Physician Certifications.

I have received, read and understand your Notice of Privacy containing a more complete description of the users and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practice from time to time and that I may contact this organization at any time at the address above to obtain a current copy of Notice of Privacy Practice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or Healthcare Operations. I also understand you are not required to agree to my requested restrictions. But if you do agree then you are bound and abided by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

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

Date:_____ Signature :_____

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105 Technology Drive, Suite G2
Trumbull, CT 06611
203-816-5545

Records Release Authorization

I hereby authorize and request you to release a copy of any recent radiographs taken within the last three (3) years.

Patient Name:

_____

Patient
Address:_____
_____
_____

Signature: _____Date: _____
(If relative, state relationship)

Please email: cappellodental@gmail.com