PATIENT REGISTRATION

PATIENT First Name: _____Last Name: _____

Middle Initial: _____Wishes to be called: _____

Female: _____Male: _____Single: _____Married: _____Divorced: _____Widowed: _____

Address: _____City: _____State: _____Zip: _____

Home Phone:_____Work Phone:_____Cell:_____

Date of Birth: _____SSN: _____Do you want to receive correspondence by email? _____

Email (if checked daily):_____

Emergency Contact Name:_____Telephone:_____

Preferred Pharmacy: _____Telephone: _____

Please bring your insurance card. We will need a copy for your records.

INSURANCE INFORMATION

Name of Insured:_____Telephone:_____

Address: _____City:_____State: _____Zip: _____

Relationship to patient: _____SSN #:_____DOB: _____

Employer: _____Group #:_____Insurance ID #: _____

Dental Insurance Co.: _____Address: _____

City: _____State: _____Zip: _____Telephone: _____

SECONDAR Y INSURANCE INFORMATION

Name of Insured: _____Telephone: _____

Address: _____City: _____State: _____Zip: _____

Relationship to patient: _____SSN#:_____DOB. _____

Employer: _____Group #: _____Insurance ID #:_____

Dental Insurance Co.: _____ Address: _____

City: _____State: _____Zip: _____Telephone: _____

How did you hear about us? _____

MEDICAL HISTORY

FOR:_____

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? Doctor's Name:	O Yes	O No	If yes, please explain:
Have you ever been hospitalized or had a major operation?	O Yes	O No	If yes, please explain:
Have you ever had a serious head or neck injury?	O Yes	O No	If yes, please explain:
Are you taking any medications, pills, or drugs?	O Yes	O No	If yes, please explain:
Do you take, or have you taken, Phen-Fen or Redux?	O Yes	O No	
Are you on a special diet?	O Yes	O No	
Do you use tobacco?	O Yes	O No	
Do you use controlled substances?	O Yes	O No	

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 ☐ Local Anesthetics

☐ Other If yes, please explain: _____

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

☐ AIDS/HIV Positive	☐ Cold Sores/Fever Blisters	☐ Glaucoma	☐ Liver Disease	☐ Sinus Trouble
☐ Alzheimer's Disease	☐ Congenital Heart	☐ Hay Fever	☐ Low Blood Pressure	☐ Spina Bifida
☐ Anaphylaxis	Disorder	☐ Heart Attack/Failure	☐ Lyme Disease	☐ Stomach/Intestinal
☐ Anemia	☐ Convulsions	☐ Heart Murmur	☐ Lung Disease	Disease
☐ Angina	☐ Cortisone Medicine	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Trouble/Disease	☐ Osteoporosis	☐ Swelling of Limbs
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Hemophilia	☐ Pain in Jaw Joints	☐ Thyroid Disease
☐ Artificial Joint	☐ Easily Winded	☐ Hepatitis A	☐ Parathyroid Disease	☐ Tonsilitis
Hip Knee Other_____	☐ Emphysema	☐ Hepatitis B or C	☐ Psychiatric Care	☐ Tuberculosis
☐ Asthma	☐ Epilepsy or Seizures	☐ Herpes	☐ Radiation Treatments	☐ Tumors or Growths
☐ Blood Disease	☐ Excessive Bleeding	☐ High Blood Pressure	☐ Recent Weight Loss	☐ Ulcers
☐ Blood Transfusion	☐ Excessive Thirst	☐ High Cholesterol	☐ Renal Dialysis	☐ Venereal Disease
☐ Breathing Problem	☐ Fainting Spells/Dizziness	☐ Hives or Rash	☐ Rheumatic Fever	☐ Yellow Jaundice
☐ Bruise Easily	☐ Frequent Cough	☐ Hypoglycemia	☐ Rheumatism	
☐ Cancer	☐ Frequent Diarrhea	☐ Irregular Heartbeat	☐ Scarlet Fever	
☐ Chemotherapy	☐ Frequent Headaches	☐ Kidney Problems	☐ Shingles	
☐ Chest Pains	☐ Genital Herpes	☐ Leukemia	☐ Sickle Cell Disease	

Have you ever had any serious illness not listed above: _____

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_____

Generations Dental Care
Dr. William R. Cummiskey
421 Hazard Avenue, Enfield, CT 06082
Email: wrcummiskeydds@yahoo.com
TEL 860-749-0533
FAX 860-749-1212

Welcome to Generations Dental Care. We're looking forward to meeting you! In preparation for your first visit we have some information for you about our office and some forms for you to complete and return to us.

We like to take a comprehensive approach to dentistry. For this reason, we'll examine your overall oral health before recommending any treatment plan. At your first visit you will likely have a periodontal evaluation of your gum tissue, full mouth cancer screening and xray evaluation as well as a cleaning.

Financial Guidelines If you do not have insurance coverage payment will be expected at the date of your treatment. We take many forms of payment; MasterCard, Visa, Discover and American Express as well as cash and check. For treatment over $300 you may be able to use CareCredit, an interest free payment program through GE Financial Corp. that allows you the option of repaying just the principal (and no additional charges) over a 6 or 12 month period. For more details log on to www.CareCredit.com, call 800-365-8295 or ask us for more information. We'd be happy to help you with your application.

Cancellation Policy You are important to us; we reserve time especially for you. If you're unable to provide us with at least 24 hours notice it puts us in a difficult position. We have other patients needing treatment that we're unable to accommodate. Because of this cancellation without 24 hours notice will incur a $50 fee.

Insurance We never guarantee coverage or amounts that will be paid for your services. Your dental benefits are based on a contract made between your employer and an employee benefits company. It is up to you to know what your insurance does and does not cover for dental benefits. There is usually a telephone number on your card. But as a service to you we will gladly submit your claims to your insurance company.

Signature_____Date_____

Print Name_____

To save time at your first visit, we'd like you to complete the enclosed Medical History and Privacy Practices and return them to us before you come in. Please also include a list of all medicines you're taking. You can mail or fax them back to us.

We look forward to meeting you. Thank you for entrusting us with your care.

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.qov

We have adopted the following policies:

1 . Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, dental insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, operatory, etc. Those records will not be available to persons Other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services. If ever there is a breach in the system, we will notify you.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, Patient/Guardian _____date _____do hereby consent and acknowledge my agreement to the terms set forth in this HIPAA INFORMATION FORM as well as any subsequent changes in office policy for_____. I understand that this consent shall remain in force from this time forward.

Patient/Guardian Signature _____

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William R. Cummiskey, DDS, LLC
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TEL (860) 749-0533
FAX (860) 749-1212

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

I authorize the release of my protected health information (chart notes and xrays) to:

Name: _____Dr William Cummiskey_____

Address: ____421 Hazard Avenue, Enfield, CT 06082

Telephone: __860-749-0533_____

PLEASE EMAIL EITHER .DEXIS OR .JPG X-RAYS TO:
wcummiskeydds@yahoo.com

_____ _____
Signature of Patient or legal guardian Date

_____

Print Name D.O.B

Please list Previous Dental office information below:

_____
Doctor Name Address Phone number