PATIENT REGISTRATION

PATIENT First Name:		Last Name:	
Middle Initial:Wis	hes to be called:		
Female:Male:Sing	gle:Married:	Divorced:	Widowed:
Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Cell:	·
Date of Birth:SS	SN:	_Do you want to receiv	e 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 y	your records.	
INSURANCE INFORMATION			
Name of Insured:		Telephone:	
Address:	City:	Sta	rte:Zip:
Relationship to patient:	SSN	#:	DOB:
Employer:	Group #:	Insuran	ice ID #:
Dental Insurance Co.:		Address:	
City:State: _	Zip:	Telephone:	:
SECONDAR Y INSURANCE INFOR	MATION		
Name of Insured:		Telephone	::
Address:			
Relationship to patient:	SSN#:	:	DOB
Employer:	Group #:	In	nsurance ID #:
Dental Insurance Co.:		Address:	
City:Sta	ate: Zip	relep	hone:

How did you hear about us?

MEDICAL HISTORY

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. I hank you for answering the following questions. Are you under a physician's care now? O Yes O No If yes, please explain: Have you ever been hospitalized or had a major operation? Are you taking any medications, pills, or drugs? O Yes O No If yes, please explain: Are you taking any medications, pills, or drugs? O Yes O No Are you taken a serious head or neck injury? O Yes O No Are you taken a serious head or neck injury? O Yes O No Are you taken a serious head or neck injury? O Yes O No Are you taken a serious head or neck injury? O Yes O No Do you take, or have you taken, Pfton-Fen or Redux? O Yes O No Are you on a special dief? O Yes O No Do you use controlled substances? O Yes O No Do you use controlled substances? O Yes O No Do you use controlled substances? O Yes O No Do you use controlled substances? O Yes O No Do you use, or have you had, any of the following? Alphality Positive O Heart If yes, please explain: Do you have, or have you had, any of the following? Alphality Positive O Code in Applyable in Arthurbur Subsea Substances Su	FOR	k:									
Are you under a physician's care now? O Yes O No If yes, please explain: Doctor's Name:	Birth	Date::									
Have you ever been hospitalized or had a major operation? O Yes O No If yes, please explain:	Altho	ough dental personnel pring or medication that you n	marily	treat the area in and arou							
Have you ever been hospitalized or had a major operation? Are you taking any medications, pills, or drugs? O Yes O No If yes, please explain: Are you taking any medications, pills, or drugs? O Yes O No Are 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 Taking oral contraceptives Are you allergic to any of the following? Other If yes, please explain: Other If yes, please explain: Women: Are you Pregnant/trying to get pregnant Auspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other If yes, please explain: Do you have, or have you had, any of the following? Alzheimer's Disease Congential Heart Hay Fever Low Blood Pressure Spina Bidida Anaphylaxis Disorder Heart Attack/Failure Lyme Disease Stomach/Intestinal Disease Arthinis/Gout Diabetes Heart Attack/Failure Lyme Disease Stomach/Intestinal Disease Artificial Heart Diabetes Heart Trouble/Disease Osteoporosis Swelling of Limbs High Knee Other Easily Winded Heaptitis B or C Psychiatric Gare Tuporilosis Tuporilosis Heart Statem Heaptitis B or C Psychiatric Gare Tuporilosis Tuporilosis Heart Statem Heaptitis B or C Psychiatric Gare Tuborilosis Tuporilosis High Blood Disease Excessive Bleeding High Blood Pressure Reeat Weight Loss Utlers Tuporilosis High Blood Disease Heart Breath High Blood Disease Heart Statem Heaptitis B or C Psychiatric Gare Tuboreal Disease Hospital Blood Transfission Excessive Bleeding High Blood Pressure Reeat Weight Loss Utlers Vellow Jaundice Hospitals B or C Psychiatric Gare Tuboreal Disease Heart Breatheta Sickle Cell Disease Heart Disease Heavestone Remail Dishys Venereal Disease Heavestone Heaventhal Heavestone Heaventhal Heaventhal Heaventhal Heaventhal Heaventhal Heaventhal Heaventhal Heaventhal Heaventhal Heav			ınder	a physician's care now?	О	Yes	O No	If yes, ple	ease explain:		
Are you taking any medications, pills, or drugs? 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 tohacco? O Yes O No Do you use tohacco? O Yes O No Taking oral contraceptives Are you allergic to any of the following? Aspirin Penicillin Codeine Aerylic Metal Latex Local Anesthetics Other If yes, please explain: Do you have, or have you had, any of the following? Albeimer's Disease Congenital Heart Hay Fever Low Blood Pressure Spina Bifda Anaphylaxis Disorder Heart Attack/Failure Lyme Disease Stomach/Intestinal Anaphylaxis Convulsions Heart Murmur Lung Disease Stomach/Intestinal Angina Cortisone Medicine Heart Pace Maker Mitral Valve Prolapse Stroke Artificial Heart Valve Drug Addiction Hempolatia Pain in Jaw Joints Thyroid Disease Artificial Joint Easily Winded Hepatitis A Parathyroid Disease Touslitis Hip Knee Other Emphysema Hepatitis B or C Psychiatric Care Tuberculosis High Blood Transfusion Excessive Bleeding High Blood Pressure Rearul Dialysis Venereal Disease Blood Disease Excessive Bleeding High Blood Pressure Rearul Dialysis Venereal Disease Blood Disease Excessive Bleeding High Blood Pressure Rearul Dialysis Venereal Disease Blood Transfusion Excessive Thirst High Cholesterol Renal Dialysis Venereal Disease Blood Disease Excessive Bleeding High Blood Pressure Scarlet Fever Yellow Jaundice Brusse Easily Frequent Cough Hypoglycemia Reheumatis Brusse Easily Frequent Cough Hypoglycemia Sickle Cell Disease Brusse Easily Frequent Cough Hypogly			zed or	had a major operation?	O Yes O No I		If yes, please explain:				
Are you taking any medications, pills, or drugs? 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 tohacco? O Yes O No Do you use tohacco? O Yes O No Taking oral contraceptives Are you allergic to any of the following? Aspirin Penicillin Codeine Aerylic Metal Latex Local Anesthetics Other If yes, please explain: Do you have, or have you had, any of the following? Albeimer's Disease Congenital Heart Hay Fever Low Blood Pressure Spina Bifda Anaphylaxis Disorder Heart Attack/Failure Lyme Disease Stomach/Intestinal Anaphylaxis Convulsions Heart Murmur Lung Disease Stomach/Intestinal Angina Cortisone Medicine Heart Pace Maker Mitral Valve Prolapse Stroke Artificial Heart Valve Drug Addiction Hempolatia Pain in Jaw Joints Thyroid Disease Artificial Joint Easily Winded Hepatitis A Parathyroid Disease Touslitis Hip Knee Other Emphysema Hepatitis B or C Psychiatric Care Tuberculosis High Blood Transfusion Excessive Bleeding High Blood Pressure Rearul Dialysis Venereal Disease Blood Disease Excessive Bleeding High Blood Pressure Rearul Dialysis Venereal Disease Blood Disease Excessive Bleeding High Blood Pressure Rearul Dialysis Venereal Disease Blood Transfusion Excessive Thirst High Cholesterol Renal Dialysis Venereal Disease Blood Disease Excessive Bleeding High Blood Pressure Scarlet Fever Yellow Jaundice Brusse Easily Frequent Cough Hypoglycemia Reheumatis Brusse Easily Frequent Cough Hypoglycemia Sickle Cell Disease Brusse Easily Frequent Cough Hypogly		Have you ever had a	a serio	ous head or neck injury?	O Yes O No		If ves. please explain:				
Do you take, or have you taken, Phen-Fen or Redux? 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 Do you use controlled substances? O Yes O No Pregnant/trying to get pregnant Nursing		•			0 105 0 110						
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 Do you use controlled substances? O yes O No Taking oral contraceptives Are you allergic to any of the following? Aspirin Penicillin Codeine Aerylic Metal Latex Local Anesthetics Other If yes, please explain: Do you have, or have you had, any of the following? AlDS/HIV Positive Cold Sorew/Fever Blisters Glaucoma Liver Disease Sinus Trouble AlZheimer's Disease Congenital Heart Hay Fever Low Blood Pressure Spina Blidd Anemia Convulsions Heart Attack/Failure Lyme Disease Stomach/Intestinal Anemia Convulsions Heart Murmur Lung Disease Disease Arthitis/Gout Diabetes Heart Place Maker Mitral Valve Prolapse Stroke Artificial Heart Valve Drug Addiction Hemophilia Pain in Jaw Joints Thyroid Disease Artificial Joint Easily Winded Hepatitis A Parathyroid Disease Tonsilitis Hij Knee Other Emphysema Hepatitis B or C Psychiatric Care Tuberculosis Ashma Epilepsy or Seizures Herpes Readiation Treatments Tumors or Growths Blood Disease Excessive Bleeding High Blood Pressure Read Neght Loss Ulcers Blood Transfusion Excessive Thirst High Cholesterol Renal Dialysis Venereal Disease Brauting Problem Frequent Cough Hypoglycemia Rheumatis Fever Yellow Jaundice Braiting Easily Frequent Grough Hypoglycemia Rheumatis Genital Herpes Leukemia Sickle Cell Disease Cancer Frequent Branches Kidney Problems Shingles Chemotherapy Frequent Headaches Kidney Problems Shingles Chemotherapy Frequent Headaches Kidney Problems Shingles Comments:					O Yes O No		If yes, please explain:				
Do you use tobacce? O Yes O No Pregnant/trying to get pregnant Nursing Taking oral contraceptives		Do you take, or have yo		•	Ο	Yes	O No				
Do you use controlled substances? Do you Pregnant/trying to get pregnant Nursing Taking oral contraceptives			Aı	• •							
Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics				•	O	Yes	O No	Women:	Are you		
Are you allergic to any of the following?		Do y	ou us	e controlled substances?	О	Yes	O No	P	regnant/trying to get preg	nant	Nursing
Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other If yes, please explain:								T	aking oral contraceptives		
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 Anaphylaxis Disorder Heart Murmur Lung Disease Disease Disease Anapina 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 Scizures 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 Bruise Easily Frequent Cough Hypoglycemia Rheumatism Rheumatism Frequent Cough Hypoglycemia Rheumatism Scarlet Fever Chemotherapy Frequent Headaches Kidney Problems Shingles Chest Pains Genital Herpes Leukemia Sickle Cell Disease Comments: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be	☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other If yes, please explain:										
Alzheimer's Disease		•	_	-		C1			T. D.		G' T 11
Anaphylaxis Disorder			_		_			_			
Anemia Convulsions Heart Murmur Lung Disease Disease Angina Cortisone Medicine Heart Pace Maker Mitral Valve Prolapse Stroke Anthritis/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 Scickle Cell Disease Have you ever had any serious illness not listed above: Comments:			Ш		_	•		_			_
Angina			П		· · · · · · · · · · · · · · · · · · ·						
Artificial Heart Valve			_					_	_	П	
Artificial Heart Valve		•			П	Heart	Trouble/Diseas	_	_		Swelling of Limbs
Artificial Joint		Artificial Heart Valve		Drug Addiction	П	Hemo	philia		_		_
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: Comments Com		Artificial Joint		•				_	Parathyroid Disease	_	-
Blood Disease		Hip Knee Other		Emphysema				Psychiatric Care		Tuberculosis	
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		Asthma		Epilepsy or Seizures	-			Radiation Treatments		Tumors or Growths	
Breathing Problem		Blood Disease		Excessive Bleeding		High l	Blood Pressure		Recent Weight Loss		Ulcers
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		Blood Transfusion		Excessive Thirst		High (Cholesterol		Renal Dialysis		Venereal Disease
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		Breathing Problem		Fainting Spells/Dizziness		Hives	or Rash		Rheumatic Fever		Yellow Jaundice
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		Bruise Easily		Frequent Cough		Hypoglycemia Rheu		Rheumatism			
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		Cancer		Frequent Diarrhea				Scarlet Fever			
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		Chemotherapy		Frequent Headaches	_ •			Shingles			
Comments: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be		Chest Pains		Genital Herpes		Leuke	mia		Sickle Cell Disease		
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be	Have you ever had any serious illness not listed above:										
SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE	dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.										

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

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.

FAX 860-749-1212

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.

<u>Financial Guidelines</u> 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.

<u>Cancellation Policy</u> 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.

<u>Insurance</u> 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.gov

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 se	t forth in this HIPAA INFO	RMATION FORM
as well as any subsequent changes in office policy for_consent shall remain in force from this time forward.	I	understand that this
Patient/Guardian Signature		

Generations Dental Care William R. Cummiskey, DDS, LLC 421 Hazard Avenue Enfield, CT 06082 TEL (860) 749-0533 FAX (860) 749-1212

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

I authorize t	he release of my protected l	health information (ch	art notes and xrays) to:
Name:	<u>Dr William Cummiskey</u>		
Address:	421 Hazard Avenue, Enf	ield, CT 06082	
Telephone:	860-749-0533		
	EMAIL EITHER .DE keydds@yahoo.com	XIS OR .JPG X-I	RAYS TO:
Signature of	Patient or legal guardian		Date
Print Name		D.O.B	
Please list P	revious Dental office inforr	nation below:	
Doctor Nam	e Ado	dress	Phone number