HEALTH HISTORY & REGISTRATION

Please fill out in entirety: all the information is important to us and to your treatment. Thanks.

Title: Mr., Mrs., Ms., Miss, Dr.

Patient's Name__________________________Home Phone Number: (   )_____________ Birth Date ___/____/____ Age____

Home Address____ City____________________ State ______ Zip _________

E-Mail Address ____ Sex: M F Social Security # ___________________

Occupation_______________________________ Employer ________________________ Work Phone # _______________

Marital Status: S M D W Spouse's Name (Parent if Minor) _______________________ Spouse's Work Number __________________

Referred to us by _________________________Reason For Visit ______________________ Cell Phone/ Pager______________________

Emergency Information

Contact Name_______________________ Daytime Phone Number __________________Address __________________________________

Primary Dental Insurance:

Policy Holders Name_____________________ Insurance Company ____________________Insurance Co. Phone Number _______________

Policy Holder's Soc. Sec. # _______________Birth Date _________________ Group or ID #_________________________

Secondary Dental Insurance:

Policy Holders Name_____________________ Insurance Company ___________________Insurance Co. Phone Number ________________

Policy Holder's Soc. Sec. # _______________Birth Date _________________ Group or ID #_________________________

Do you have any current health problems? Yes No If yes, What ____

Are you under a Physicians care now? Yes No For What? ____

Are you currently taking any medication? Yes No If Yes, What?____

Are you allergic to or have you reacted adversely to any medications or substances? If yes List:

Circle any of the following, which you have had or have at present:

Heart failure	Cardiac By Pass	Bleeding Disorders	Artificial Joints	HIV/ AIDS
Heart Disease or Attack	Hepatitis A(infectious)	Anemia	Diabetes	Angina/Chest Pain
Hepatitis B(serum)	Tuberculosis(TB)	Stroke	Chemotherapy/Radiation	High Blood Pressure
Asthma/Emphysema	Kidney Disease	Fainting or Dizzy Spells	Heart Murmur/MVP	Yellow Jaundice
Hay fever	Ulcers	Rheumatic Fever	Blood Transfusion	Sinus Trouble
Cosmetic Surgery	Arthritis	Congenital Heart Lesions	Drug Addiction	Allergies or Hives
Pain in Jaw Joints	Artificial Heart Valve	Fever Blisters	Thyroid Disease	Sickle Cell Disease
Venereal Disease	Heart Pacemaker	Epilepsy or Seizures	Glaucoma	Current Pregnancy

Family Physician __________________________ Address__________________________ Phone Number___________________________

Is there any other Medical or Dental information we should know? ____

Consent:

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnostic of patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. To my knowledge I have given an accurate report of my physical and mental health history. I also understand the use of an anesthetic agent embodies a certain risk. I understand that responsibility for payment for Dental services in this office for my dependents or myself is mine, due and payable at the time services are rendered unless financial arrangements have been made. Financial agreement: Patient agrees to pay finance charge of 1_% monthly (18% APR) plus collection costs, court costs and reasonable attorney fees on any unpaid balance. I also assign all Insurance benefits to the Doctor.

Patient Signature _______________________Date__ /___/___ Dentist Signature____________________________

(Parent if patient is a minor)

COMPREHENSIVE DENTAL HEALTH, LLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT OUR PRIVACY OFFICE AT THE PHONE NUMBER ON THE BACK OF THIS NOTICE. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR COMMITMENT TO YOU

We recognize that medical information about you is personal and are committed to protecting that information. We create medical records in order to provide you with the best quality care and service and promise to maintain the strictest reasonable privacy in order to protect you and to comply with federal and state legal requirements. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

We may use and disclose health information about you for treatment, payment, and healthcare operations *without* your prior authorization in the following manner:

- We may use or disclose your health information to a physician or other healthcare provider providing treatment to you and to provide you with information about treatment alternatives that may be of interest to you.
- We may use and disclose your health information to obtain payment for services we provide to you.
- We may use and disclose your health information in connection with our healthcare operations, including quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
- We may use or disclose your health information to provide you with appointment reminders (such as telephone messages, postcards, or letters).
- We will share your health information, as necessary, with third party “business associates” that perform various activities for Comprehensive Dental Health, LLC. We will have a written contract that contains terms and conditions to protect the privacy of your health information.

We may use or disclose your health information *without* your prior authorization or consent when required to do so by law, by appropriate authorities in military or correctional institutions, departments of public health, communicable diseases, food and drug administration, or by funeral directors, coroners, law enforcement, or for health oversight audits, legal proceedings, organ donation, or in cases of suspected abuse, neglect, or domestic violence or for purposes of national security.

In certain circumstances we may use and disclose health information about you *without* your prior authorization provided you are informed in advance and given the opportunity to agree to or prohibit or restrict the disclosure. If you are not present or able to agree or object to the use or disclosure, then your dentist may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

- We may use or disclose your health information in an emergency treatment situation. We will try to obtain your consent as soon as reasonably practicable after delivery of treatment.
- We may disclose your health information to a family member, friend or other person whom you designate to the extent necessary to help with your healthcare or with payment for your healthcare.
- We may use or disclose your health information to notify or assist in notifying a family member, personal representative or any other person that is

responsible for your care, of your location, general condition, or death.

• We may disclose your health information to a public or private entity authorized by law or charter to assist in disaster relief efforts, but only for the purpose of coordinating with such entities.

• We will ***not*** use your health information for marketing communications without your written authorization.

• In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

YOUR RIGHTS AS OUR PATIENT

RIGHT TO ACCESS/AMEND YOUR RECORDS OR REQUEST AN ACCOUNTING
In most cases, you have the right to look at or get copies of your health information, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing, or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision. You also have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

You have the right to request a list accounting for any disclosure of your health information we have made, except for uses and disclosure for treatment, payment, and healthcare operations, circumstances in which you have specifically authorized such disclosure and certain other exceptions. Your written request must specify the relevant period, no more than the last six years and not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

RIGHT TO REQUEST RESTRICTIONS
You have the right to request, in writing, that we place additional restrictions on our use or disclosure of your health information. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

RIGHT TO CONFIDENTIAL COMMUNICATIONS
You have the right to request, in writing, that we communicate with you about your health information by alternative means or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Office Manager

Dental Practice: Comprehensive Dental Health, LLC

389 Orange Street, New Haven, CT 06511

203-624-5515

REV: July 3, 2003