CHARLES C. GUCK, D.M.D.
201 MAIN STREET NORTH
SOUTHBURY, CT 06488
(203)264-8995

NAME _____ HOME PHONE # _____

ADDRESS _____ CELL PHONE # _____

CITY _____ STATE _____ ZIP _____ E-MAIL _____

SEX ___M ___F AGE _____ BIRTHDATE _____ ___MARRIED ___WIDOWED ___SINGLE ___MINOR
___SEPARATED ___DIVORCED ___PARTNERED FOR ___YRS

CAN THE OFFICE LEAVE A DETAILED MESSAGE REGARDING YOUR APPOINTMENT/TREATMENT? ___YES ___NO
PLEASE INDICATE TELEPHONE NUMBER _____

PATIENT EMPLOYER/SCHOOL _____ OCCUPATION _____

EMPLOYER/SCHOOL ADDRESS _____ EMPLOYER/SCHOOL PHONE # _____

IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED _____ PHONE #_____

PRIMARY DENTAL INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT _____ RELATION TO PATIENT _____ PHONE #_____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMPLOYER _____ EMPLOYER ADDRESS _____

INSURANCE COMPANY _____ INSURANCE COMPANY ADDRESS _____

BIRTHDATE _____ SOC. SEC. # _____ PATIENT ID# _____ GROUP # _____

SECONDARY DENTAL INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT _____ RELATION TO PATIENT _____ PHONE #_____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMPLOYER _____ EMPLOYER ADDRESS _____

INSURANCE COMPANY _____ INSURANCE COMPANY ADDRESS _____

BIRTHDATE _____ SOC. SEC. # _____ PATIENT ID# _____ GROUP # _____

AUTHORIZATIONS

I CERTIFY THAT I, AND/OR MY DEPENDENTS(S) HAVE INSURANCE COVERAGE WITH _____AND ASSIGN DIRECTLY TO DR. CHARLES C. GUCK ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS.

I ACKNOWLEDGE THAT PAYMENT IS DUE AT THE TIME OF TREATMENT UNLESS OTHER ARRANGEMENTS ARE MADE. I AGREE THAT PARENTS, GUARDIANS OR PERSONAL REPRESENTATIVES ARE RESPONSIBLE FOR ALL REES AND SERVICES FOR TREATMENT OF A MINOR/CHILD. I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ALL CHARGES FOR SERVICE OR ITEMS PROVIDED TO ME OR THE PATIENT. I UNDERSTAND THAT FILING A CLAIM WITH MY INSURANCE COMPANY DOES NOT RELIEVE ME OF MY RESPONSIBILITY OFR THE PAYMENT OF ALL CHARGES.

HIPAA PRIVACY PRACTICES ACKNOWLEDGEMENT

I, _____, HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THE CONTENTS OF THIS CONSENT FORM AND YOUR NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT BY SIGNING THIS FORM I AM GIVING MY CONSENT FOR YOUR USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES AND HEALTHCARE OPERATIONS.

SIGNATURE _____ DATE _____

DENTAL HISTORY

REASON FOR TODAY'S VISIT _____ DATE OF LAST DENTAL CARE _____

FORMER DENTIST _____ DATE OF LAST DENTAL X-RAYS _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CHECK IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING:

___BAD BREATH
___BLEEDING GUMS
___CLICKING OR POPPING JAW
___FOOD COLLECTION BETWEEN TEETH
___GRINDING TEETH
___LOOSE TEETH OR BROKEN FILLINGS
___SENSITIVITY WHEN BITING
___SENSITIVITY TO COLD / HOT / SWEETS
___SORES OR GROWTH IN YOUR MOUTH
___ORTHODONTIC TREATMENT
___PERIODONTAL TREATMENT
___ROOT CANAL TREATMENT

HOW OFTEN DO YOU FLOSS? _____ HOW OFTEN DO YOU BRUSH? _____

MEDICAL HISTORY

PRIMARY
PHYSICIAN'S NAME _____ DATE OF LAST VISIT _____

OTHER MEDICAL PROVIDERS _____

DO YOU REQUIRE ANTIBIOTICS BEFORE DENTAL TREATMENT? ___YES ___NO REASON _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? ___YES ___NO IF YES, GIVE APPROXIMATE DATES _____

(WOMEN) ARE YOU PREGNANT? ___YES ___NO DUE DATE _____ NURSING? ___YES ___NO BIRTH CONTROL PILLS ___YES ___NO

CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

___ANEMIA
___ANXIETY
___ARTHRITIS, RHEUMATISM
___ARTIFICIAL HEART VALVES
___ARTIFICIAL JOINTS
___ASTHMA
___BACK PROBLEMS
___BLOOD DISEASE
___CANCER
___CHEMICAL DEPENDENCY
___CHEMOTHERAPY
___CIRCULATORY PROBLEMS
___CORTISONE TREATMENTS
___COUGH, PERSISTENT
___COUGH UP BLOOD
___DEPRESSION
___DIABETES
___EATING DISORDER
___EPILEPSY
___FAINTING, DIZZINESS
___GLAUCOMA
___HEADACHES
___HEART MURMUR
___HEART PROBLEMS
___HEMOPHILIA
___HEPATITIS
___HIGH BLOOD PRESSURE
___HIV/AIDS
___JAW PAIN
___KIDNEY DISEASE
___LIVER DISEASE
___MITRAL VALVE PROLAPSE
___PACEMAKER
___PSYCHIATRIC ILLNESS
___RADIATION TREATMENT
___RESPIRATORY DISEASE
___RHEUMATIC FEVER
___SHORTNESS OF BREATH
___SKIN RASH
___SEXUALLY TRANSMITTED DISEASE
___STROKE, TIA
___SWELLING OF FEET OR ANKLES
___THYROID PROBLEMS
___TOBACCO HABIT
___TUBERCULOSIS
___ULCER

NOTES : _____

MEDICATIONS:
PLEASE LIST ALL MEDICATIONS YOU ARE TAKING: _____

SUPPLEMENTS INCLUDING VITAMINS _____

ALLERGIES:

___ASPIRIN
___BARBITURATES
___CODEINE
___LOCAL ANESTHETIC
___PENICILLIN
___SULFA
___LATEX
___OTHER_____
_____

CERTIFICATION

I AFFIRM THAT THE INFORMATION I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. IT WILL BE HELD IN THE STRICTEST CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS. I AUTHORIZE THE DENTAL STAFF TO PERFORM THE NECESSARY DENTAL SERVICES I MAY NEED.

PATIENT'S SIGNATURE _____ DATE _____

DOCTOR'S SIGNATURE _____ DATE _____