University of Connecticut Health
School of Dental Medicine
PATIENT REGISTRATION

Patient Identification #

PATIENT INFORMATION

Name: LAST, FIRST, M.I.				Date:
Screening Date:	Date of Birth:	Social Security No.	Male ☐ Female ☐	Spouses' Name:
Home Address/Street		City, State, Zip Code		Telephone: Daytime: Evening:
Change of Address/Street		City, State, Zip Code		Telephone: Daytime: Evening
Change of Address/Street		City, State, Zip Code		Telephone: Daytime: Evening

Signature of Patient/	Signature of Witness:	Date:
Name of Guarantor	Guarantor's Address (City, State, Zip Code)	Date:
Occupation:	Employee/Business Address	Change of Employer/Business Address

METHOD OF PAYMENT

☐ Self-pay ☐ State Welfare/ID No:_____ ☐ City Welfare/ID No._____

DENTAL INSURANCE DATA

Insurance Company (Primary)		Program	Policy No.
Name of Insured Person	Date of Birth	Relationship to Patient ☐ Self ☐ Spouse ☐ Parent	Employer
Insurance Company (Primary)		Program	Policy No.
Name of Insured Person	Date of Birth	Relationship to Patient ☐ Self ☐ Spouse ☐ Parent	Employer

Signature of Patient/Guardian _____ Signature of Witness _____ Date _____

UCONN
HEALTH

(Patient Identification)

CONSENT TO TREATMENT AND THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

CONSENT TO TREATMENT: For purposes of my clinical care I, the undersigned, consent to treatment by the University of Connecticut Health Center*. I consent to any routine diagnostic procedures (including voluntary testing for HIV) or other medical/dental procedures of examination and any other service rendered to me under the general and specific instruction of my physician/dentist. I consent to the use of photography, audio or videotaped data for purposes of my clinical care. I have been informed that because UConn Health is an academic medical center, medical and dental students may be in attendance while my care is being provided. Additionally, I have been informed that, absent extraordinary circumstances, invasive procedures of a non-routine nature will not be performed without my prior written consent.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: Subject to the notices printed on this form I hereby consent to have UConn Health use my information, including, if applicable, Protected Health Information ("PHI"), including drug and/or alcohol abuse information, psychiatric information, and HIV- related information, for treatment, payment and health care operations. In addition, I have been informed that UConn Health may disclose or allow electronic access to my PHI for purposes of my treatment and coordination of care to my primary care provider, my referring physician, and other health care providers. I have also been informed that UConn Health will communicate with me using the email address I provide to them. Communication using email will allow me to set up my own electronic access to obtain available health information, complete surveys about my care, and communicate with my care team. I also authorize UConn Health to disclose my PHI to the "payer" covering my care. A payer is any 3rd party which has agreed to provide payment for the care that I will receive as a patient of UConn Health (i.e. health insurance plan). I have been informed that if I do not want my payer to receive my PHI, I must state in writing my request to restrict a disclosure to my Health Plan and self-pay for the services. Under Connecticut law, all self-pay patients, upon request, may receive a copy of the John Dempsey Hospital's charges related to their care. Patient Account Representatives may be reached at 860-679-2000.

I acknowledge that I have received a copy of UConn Health's Notice of Privacy Practices which explains how they may use and disclose my PHI. I have been informed that I have the right to review such Notice before signing this consent. I also have been informed that UConn Health reserves the right to change its privacy practices described in its Notice, and that if I wish to receive notification of any changes to the notice, I may contact UConn Health's Privacy Officer. See http://www.uchc.edu/disclaimer/privacy.html I have the right to request that UConn Health restrict how PHI about me is used or disclosed for treatment, payment or health care operations, and I have been informed that UConn Health is not required to agree to this restriction. If UConn Health does agree to a restriction I request, UConn Health will be bound by our agreement.

This consent will be valid for a period of one year from the date below. I have been informed that I have the right to revoke this consent by contacting the UConn Health, Health Information Management Department, except where UConn Health has already taken action in reliance on this consent.

I have had an opportunity to have all my questions answered regarding UConn Health's privacy practices. I have received a copy of the Notice of Privacy Practices and consent to the use and disclosure of my PHI for treatment, payment and health care operations.

* All of the following entities including all locations both on and off campus are collectively "UConn Health": John Dempsey Hospital, UConn Medical Group (UMG), University of Connecticut School of Medicine, University Dentists, University of Connecticut School of Dental Medicine.

HCH901

UCONN HEALTH

(Patient Identification)

Any information released by UConn Health to authorized persons is subject to the notices below on this form:

NOTICES

Psychiatric Information:

In the event that information released constitutes confidential psychiatric information protected under Connecticut law:

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making further disclosure of it or of using it for any purpose other than that indicated above without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law.

Drug and Alcohol Abuse Information:

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

HIV-Related Information:

In the event that information released constitutes confidential HIV-related information protected under Connecticut law:

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

ASSIGNMENT AND AUTHORIZATION MEDICARE/MEDICAID/COMMERCIAL INSURANCE CERTIFICATION: I certify that the information given by me in applying for payment by Medicare or Medicaid under Title XVIII of the Social Security Act, general assistance, or a commercial insurance carrier is correct. I authorize any holder of medical or other information about me to release to these third-party payers any information needed for payment. I request the payment of authorized benefits be made on my behalf. I assign the benefits payable for UConn Health (physicians or other ordering providers) furnishing services to me, and authorize UConn Health to submit claims to potential third-party payers for me. I request that this authorization apply to all services associated with my care.

Patient Signature or Authorized Representative** _____ Date _____ Time □ AM □ PM _____

Print Name _____ Personal Email Address _____

****Note**, if signing on behalf of the patient, I have proven my identity and/or relationship to the patient as:
□ Parent; □ Guardian; □ Authorized Representative (describe):_____

FOR STAFF USE ONLY: If unable to obtain patient's consent or provide Notice of Privacy Practices, indicate the reason: □ Emergency; □ Patient refusal; □ Other: _____

University of Connecticut
Health Center

School of Dental Medicine | Health Questionnaire

For Official Use Only:
Place registration sticker here or enter
TOO# _____

Patient Name: _____ **Patient Date of Birth:** ____/____/____

Why have you come to the School of Dental Medicine: _____

_____

Physician List (please list all physicians you are currently seeing or have seen recently):

Name: Address: Phone: Specialty:

_____

_____

_____

MEDICAL HISTORY (please circle below)

Yes No Have you had any serious illness, operation or been hospitalized in the past 5 years?

If so, what was the illness or problem: _____

Yes No Do you have (or have you ever had) heart disease? If yes, please circle:

Heart attack	High blood pressure	Angina (chest pains)
Congestive heart failure	Heart murmur or valve disease	Artificial valve(s)
Rheumatic heart disease	Irregular heartbeat	Pacemaker

Yes No Bleeding problem, anemia or other blood disease

Yes No Diabetes

Yes No Asthma

Yes No Tuberculosis

Yes No Other respiratory or lung problems

Yes No Stomach or intestinal disease

Yes No Hepatitis (A, B, C, or D)

Yes No Other liver disease

Yes No Arthritis

Yes No Immunosuppressive condition. If yes, please circle

Steroid therapy Radiation therapy Chemotherapy HIV

Yes No Cancer

Patient Name: _____

For Official Use Only:
Place registration sticker here or enter
TOO# _____

Yes No Are you or could you be pregnant?

Yes No Are you nursing?

Yes No Do you have (or have you had) any disease, condition, or problem not listed above? If yes, please describe:

_____

Yes No Do you have any artificial joints? If so, when were they placed: _____

Yes No Do you smoke or use tobacco products?

Yes No Do you (or have you) used drugs or other substances for recreational purposes?

Yes No Do you drink alcoholic beverages? If so, how frequently: _____

Yes No Are you currently being treated (or have you been treated) with medication for osteoporosis?

Please list all current medications you are taking: _____

_____

_____

Do you take any herbal medicines or dietary supplements? Please list any: _____

_____

Do you have any allergies? Please list any: _____

_____

DENTAL HISTORY

Yes No Have you had regular dental check-ups? When was your last dental exam: _____

Yes No Have you had any problems with previous dental treatment? If yes, please describe: _____

_____

Yes No Have you noticed any lumps or sores in your mouth?

Yes No Do your gums bleed when you brush your teeth?

Yes No Do you have any pain in the mouth or face?

Yes No Has fear or anxiety ever prevented you from seeking dental treatment?

To the best of my knowledge, the information I have provided above is complete and accurate.

_____ _____
Patient Signature (or Legal Guardian) **Date**

THE UNIVERSITY OF CONNECTICUT HEALTH CENTER SCHOOL OF DENTAL MEDICINE REQUESTS THIS INFORMATION FOR THE PURPOSE OF PROVIDING A COMPLETE AND COMPREHENSIVE EVALUATION OF YOUR DENTAL NEEDS. NO PERSON OUTSIDE OF THE SCHOOL WILL BE PROVIDED WITH THIS INFORMATION UNLESS AUTHORIZED BY YOU OR REQUIRED BY LAW.