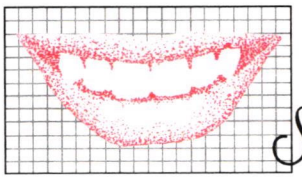
Welcome



Steven M. Balloch, D.D.S.

Personalized, state-of-the-art cosmetic dental care for beautiful smiles

The benefits of a happy, beautiful smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out the form completely. The better we communicate, the better we can care for you.

1 About You

Today's Date: ____/____/____

Name: _____

I prefer to be called: _____ Male Female

Birthdate: ____/____/____ SS#: _____

Home Address: _____

_____

Single Married Divorced Widowed Separated

Hm#: (____) _____ Cell Phone #: _____

Wk #: (____) _____ Ext: _____ DL# _____

E-mail: _____

Responsible Party: _____

Employer: _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____

Last Visit Date: ____/____/____ Ph#: _____

2 Spouse Information

His / Her Name: _____

Employer: _____

Wk #: (____) _____ Ext: ____ SS#: _____

Birthday: ____/____/____ DL #: _____

3 Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ____/____/____ Insured's SS#: _____

Insured's Employer: _____

Secondary Dental Insurance:

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's SS #: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name / Relationship: _____

Employer: _____

Wk #: (____) _____ Ext: ____ Hm#: _____

CONTINUED ON BACK

4 Medical History

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Are you taking any prescription/over-the-counter drugs? Yes No

Please list each one: _____

Do you smoke or use tobacco in any other form? Yes No

For Women: Are you taking birth control pills? Yes No

Are you pregnant? Yes No Week #: _____

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding	Y N Hepatitis
Y N Alcohol/Drug Abuse	Y N Herpes/Fever Blisters
Y N Anemia	Y N High Blood Pressure
Y N Arthritis	Y N HIV+/AIDS
Y N Artificial Bones/Joints/Valves	Y N Hospitalized for any Reason
Y N Asthma	Y N Kidney Problems
Y N Blood Transfusion	Y N Liver Disease
Y N Cancer/Chemotherapy	Y N Low Blood Pressure
Y N Colitis	Y N Mitral Valve Prolapse
Y N Congenital Heart Defect	Y N Pacemaker
Y N Diabetes	Y N Psychiatric Problems
Y N Difficulty Breathing	Y N Radiation Treatment
Y N Emphysema	Y N Rheumatic/Scarlet Fever
Y N Epilepsy	Y N Seizure
Y N Fainting Spells	Y N Shingles
Y N Frequent Headaches	Y N Sickle Cell Disease
Y N Glaucoma	Y N Sinus Problems
Y N Hay Fever	Y N Stroke
Y N Heart Attack	Y N Thyroid Problems
Y N Heart Murmur	Y N Tuberculosis (TB)
Y N Heart Surgery	Y N Ulcers
Y N Hemophilia	Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Tetracycline
Y N Codeine	Y N Latex	Y N Other
Y N Dental Anesthetics	Y N Penicillin	

Please list any other drugs that you are allergic to: _____

_____

5 Dental History

Why have you come to the dentist today? _____

_____

Many patients consult us for a second opinion. Are you currently seeing another dentist? for your dental needs?

If yes, please explain: _____

How would you describe the condition of your teeth and gums?
Good Fair Poor

Are you currently in pain or discomfort with your teeth or gums? Yes No
If yes, please explain: _____

How often do you brush your teeth? Floss your teeth?

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

Have you ever experienced pain in your jaw joint? Yes No

Have you ever been treated for TMJ symptoms? Yes No

If yes, please explain: _____

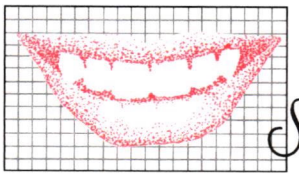
_____

Do you grind or clench your teeth? Yes No

I understand that the information is correct to the best of my knowledge. I understand 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 any necessary dental services that I may need during diagnosis and treatment with my informed consent. I also give permission for the doctor or his staff to use any photos he may take to be used for lecturing, publishing, or education purposes.

signature _____ *date* _____

Patient portion is due in full at the time of treatment.



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INITIAL CLINICAL INTERVIEW

Patient Name	Wishes to be Called
Patient Account No.	Date

What is the most important thing we can do for you today? _____

_____

Date of Last Dental Visit	Date of Last Dental Cleaning	Date of Last Full Mouth Series

1. Do you have any areas in your mouth that concern you now? yes no

2. Are any of your teeth sensitive to:
   - hot yes no
   - cold yes no
   - sweets yes no
   - pressure yes no

3. Have you ever had:
   - orthodontic treatment? yes no
   - oral surgery? yes no
   - periodontal treatment? yes no
   - your bite adjusted? yes no
   - worn a bite plate? yes no

4. Have you noticed:
   - loosening of your teeth? yes no
   - food catching between your teeth? yes no
   - pain/swelling of your gums? yes no
   - gums ever bleed when brush or floss? yes no
   - bad breath? yes no
   - sore areas in mouth? yes no

5. Have you ever heard of periodontal disease? (You might have heard it called pyhorrea or gum disease.) yes no

   Have you ever been examined for it? yes no

6. Have you experienced:
   - clicking in the jaw? yes no
   - pain (joint, ear, side of face)? yes no
   - difficulty in opening/closing? yes no
   - difficulty chewing? yes no

7. Do you, or have you ever been told that you:
   - clench or grind your teeth? yes no
   - bite your lips/cheek yes no
   - hold foreign objects with your teeth? yes no
   - breathe through your mouth while awake/asleep? yes no

8. What would you like to change about the appearance of your teeth? _____

_____

9. What's most important to you in a dentist? _____

_____

10. What are your expectations of our office? _____

_____

11. What did you like best about your previous dentist? ____

_____

What did you like least? _____

_____

12. How long do you want to keep your teeth? _____

_____

13. Do you want the very best dentistry we can offer you, or do you just want to get by? _____

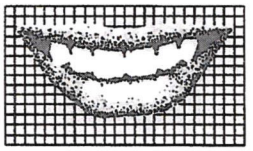
_____

14. If we find something that needs to be done in your mouth, do you want all of the details about it, or do you want an overview?

details big picture

15. When there is something to be done, do you tend to wait until a problem arises, or do you prefer to handle it before there is a crisis?

necessity possibility



STEVEN M. BALLOCH, D.D.S.
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Patient name: _____

Name of parent/guardian: _____
(If signing for a minor)

❖ **Acknowledgement of Receipt of Notice of Privacy Practices**
It is our policy, and our promise to our patients, to only use personal information given by you to submit insurance claims, or given information to a referral doctor's office. I have reviewed the HIPAA policy and understand the office's Notice of Privacy Practices.

Signature: _____ **Date:** _____

(Optional): I wish to authorize the individual(s) listed below to request my dental records or other transaction based records:
Name/Relationship: _____

❖ **Authorization to e-mail digital records to specialists & other practices:**
By signing below I authorize Dr. Balloch or designated staff members to e-mail x-rays, or other treatment records I may request to myself or a specified dental/medical professional. Refusal to sign will result in all records requests being signed for by me and mailed out with at least 24-hours' notice beforehand.

Signature: _____ **Date:** _____

❖ **Authorization of informed consent:**
By signing below I authorize Dr. Balloch or designated staff members to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I have also been informed that the portion of services unpaid by insurance is due in full at the time of treatment.

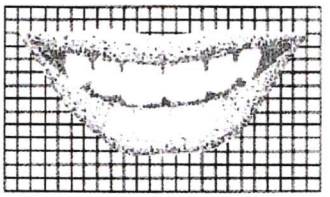
Signature: _____ **Date:** _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify):

Glastonbury Medical Arts Center ♦ 300 Hebron Ave Suite 112 ♦ Glastonbury CT 06033 ♦ P:(860)659-8660 ♦ F:(860)633-6229 www.hartfordcosmeticdentist.com



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Record Transfer Request

I, (Patient's Name):_____ **Date of Birth:** _____

am authorizing the following dentist/office to release copies of dental x-rays on file.

Dentist (Office) Name: _____

Address: _____

_____

Phone: _____

Patient's Signature: _____ **Date:** _____

Please send x-rays/records to: Steven M. Balloch, D.D.S.
300 Hebron Avenue, Suite 112
Glastonbury, CT 06033

Email (preferred): sballoch@hartfordcosmeticdentist.com

Additional requests and/or reason for transfer of dental records (optional):