Dr. Neil Hoss, DMD, LLC
Patient Registration

Patient Information:

Last Name: ____________________ First Name: ________________ Middle Initial: ___

Home Phone: Work: ________________ Cell: ________________

Date of Birth: _________ SS# __________________ E-Mail: ______________________

Address: _____________________________ Apt #: ____ City: ___________________

State: ____ Zip _________ Referred By: _______________________________

Are you Single ___ Married ___ Divorced ___ Widowed ___

Spouse's Name: ______________________

Date of Last Dental Exam: _ Reason for Today's Visit:

Responsible Party:

(If patient is Younger than 18 years old)
Who is responsible for paying this account? ___________________
Relations: _________

Dental Insurance Information:

Policy Holder: ____________________ Insurance Company: __________________
Policy Holder DOB: ______________ Policy Holder SS# ____________________
ID#: _________________________ Group#: ___________________
Ins. Company Claim Address: ____
Employer: _____________________ Occupation: ______________________

Informed Consent, Assignment of Insurance Benefits, HIPPA:

Time is very valuable. When you schedule an appointment, that time is reserved for you. If you are unable to keep an appointment we require 24 hour notice. We reserve the right to charge a $75 fee for broken appointments.

I authorize payment of dental insurance benefits to Dr. Neil Hoss and understand that as a service Dr. Hoss will file insurance claims. I understand that my dental insurance policy is an agreement between my insurance company and myself. I understand that payment for dental services rendered are my full responsibility and payment is due at time of service. I understand Dr. Hoss does not participate with All Insurance companies.

I authorize Dr. Hoss to send reminder texts and phone calls. I have received Notice of Privacy Practices.

Print Name **Sign Name** **Date**

Medical History

Medications: ____

____

Allergies:____

Emergency Contact: ______________________ ***Phone #:*** __________________

Relationship: ______ __________

Physician: ____________________ Town: ___________ Phone #: ______________

Pharmacy: ____________________ Town: ___________ Phone #: ______________

Have you ever had, or do you have now, any of the following?

YES	NO		YES	NO	
•	•	Rheumatic Fever	•	•	Epilepsy/ Seizure
•	•	Diabetes	•	•	Asthma
•	•	Jaundice/ Liver Disease	•	•	Cancer
•	•	Kidney Problems	•	•	Artificial Joints/ Prosthetics
•	•	Stomach Problems	•	•	Radiation/ Chemotherapy
•	•	Acid Reflux	•	•	HIV/ AIDS
•	•	Arthritis	•	•	Hepatitis
•	•	Osteoporosis	•	•	Venereal Disease
•	•	Thyroid Disorder	•	•	Tuberculosis
•	•	Heart Disease	•	•	Heart Valve Implant
•	•	Mitral Valve Prolapse	•	•	Psychiatric Treatment
•	•	Heart Murmur	•	•	Are You Pregnant?
•	•	Pacemaker	•	•	High Cholesterol
•	•	High/Low Blood Pressure	•	•	Major Surgery

- Have You been Diagnosed with Sleep Apnea? Yes/No
- Other conditions: ____

Have you ever experienced any of the following?

YES	NO		YES	NO	
•	•	Swelling of the Ankles	•	•	Persistent Cough
•	•	Bruise Easily	•	•	Pain, Pressure in Chest
•	•	Excessive/Prolonged Bleeding	•	•	Shortness of Breath
•	•	Frequent Headaches	•	•	Frequent Urination
•	•	Dizziness	•	•	Frequent Thirst
•	•	Slow Healing	•	•	Unexplained Weight Loss or
			•	•	Shortness of Breath while Lying Down

Patient Signature: ____________________________________ Date: _________

Dr Neil Hoss DMD, LLC
115, Hartford Turnpike, Tolland CT 06084

HIPPA Notice of Privacy Practices
Patient Consent Form

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Effective 12/22/2020.

I am committed to maintaining clients' confidentiality. I will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession. This notice describes my policies related to the use and disclosure of your healthcare information.

Use and disclosure of protected health information is for the purpose of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Treatment: I may need to use or disclose health information about you to provide, manage, or coordinate your care or related services. This includes consultants and potential referral sources.

Healthcare Operations: I may need to use information about you to review my treatment procedures and business activity. Information may be used for certification, compliance, and licensing activities. Other examples include contacting you regarding scheduling appointments.

Other use or disclosures of your information which do not require your consent: There are some instances where I may be required to use and disclose information without your consent. For example (but not limited to): Information you and/or your child (ren) report about physical or sexual abuse; then by Connecticut State Law I am required to report this to the Department of Children and Family Services; Information provided by you that informs us that you are in danger of harming yourself or others; Information to remind you about or to reschedule appointments or treatment alternatives; Information shared with law enforcement, or when permitted by law.

I reserve the right to change the terms of this notice and will inform you in writing of any changes. You then have the right to object or withdraw as provided in this notice.

I, ______________________________, have received a copy of this office's Notice of Privacy Practices

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Please Print Name

_________________________________ ________________________

Signature Date