Patient Registration

FORM DATE: ___/___/_____

Patient ID: _____ Chart ID: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐

First Name **Middle Initial** **Last Name**

Other Physician Name

Responsible Party (If someone other than patient)

Name

Patient Information

Street Address

City State Zip

Home Phone ( ) - Work Phone ( ) - Cell Phone ( ) -

Sex: ☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: ___/___/_____ Social Security Number _____-_____-_____

E-mail Spouse Name

☐ Employed Student Status ☐ Full Time ☐ Part Time Height: Feet Inches

☐ Allow Spouse to Review Records

Family Dentist

Medical Insurance Information

Primary Medical Insurance Information

First Name of Insured: Last Name Middle Initial

Policy/Group No. Relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance ID No. Insured Birth Date ___/___/_____ Plan Name

Employer Ins. Company

Insured Address if different than patient's

Street Address Street Address

City, State, Zip City, State, Zip

Patient Signature: Date:

Secondary Medical Insurance Information

First Name of Insured: Last Name Middle Initial

Policy/Group No. Insurance Plan or Program Name

Insured Birth Date ____/____/_____ Sex: ☐ Male ☐ Female Insurance ID No.

Employer Ins. Company

Insured Address if different than patient's

Street Address Street Address

City, State, Zip City, State, Zip

Patient Signature: Date:

Patient Signature

Because of HIPAA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By agreeing to this consent, you permit the release of any information to or from your dental practitioner as required including a full report of examination findings, diagnosis and treatment program to any referring or treating dentist or physician. You understand that you are financially responsible for all charges whether or not paid by insurance. Your dental practitioner may use your health care information and may disclose such information to your Insurance Company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.

Patient Signature: _____ Date: _____

I certify that the medical history information is complete and accurate.

Patient Signature: _____ Date: _____

Version: SLPQV2

Sleep History/Exam/Workup Questionnaire

OFFICE USE
Patient ID:____

NAME: _____ CURRENT DATE: ___/___/_____

DATE OF BIRTH: ___/___/_____ ☐ MALE ☐ FEMALE

Referring Physician: Contact ID:

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

1. Please **number** your complaints with #1 being the most severe, #2 the next most severe, etc.

2. Then rate your complaints for frequency and intensity:

Frequency
1-SELDOM 2-OCCASIONAL 3-FREQUENT 4-EVERYDAY

Intensity
0=NO PAIN and 10 is MOST SEVERE PAIN

Number #1 = the most severe symptom		Frequency 1-4	Intensity 1-10
☐	CPAP intolerance	☐	☐
☐	Difficulty concentrating	☐	☐
☐	Excessive daytime sleepiness	☐	☐
☐	Fatigue	☐	☐
☐	Forgetfulness	☐	☐
☐	Frequent snoring	☐	☐
☐	Gasping causing waking up	☐	☐

Number #1 = the most severe symptom		Frequency 1-4	Intensity 1-10
☐	Impaired thinking	☐	☐
☐	Insomnia	☐	☐
☐	Morning headaches	☐	☐
☐	Nighttime choking spells	☐	☐
☐	Snoring which affects the sleep of others	☐	☐
☐	Witnessed cessation of breathing	☐	☐

Other: Write In

Epworth Sleep Questionnaire

How likely are you to doze off or fall asleep in the following situations?

No chance of dozing	**Slight** chance of dozing	**Moderate** chance of dozing	**High** chance of dozing	
☐	☐	☐	☐	Sitting and reading
☐	☐	☐	☐	Watching TV
☐	☐	☐	☐	Sitting inactive in public place (e.g. a theater or a meeting)
☐	☐	☐	☐	As a passenger in a car for an hour without a break
☐	☐	☐	☐	Lying down to rest in the afternoon when circumstances permit
☐	☐	☐	☐	Sitting and talking to someone

Patient Signature: Date:

Epworth Sleep Questionnaire

How likely are you to doze off or fall asleep in the following situations?

No chance of dozing	Slight chance of dozing	Moderate chance of dozing	High chance of dozing	
☐	☐	☐	☐	Sitting quietly after a lunch without alcohol
☐	☐	☐	☐	In a car, while stopped for a few minutes in traffic

SLEEP STUDIES

If you have had a Sleep Study, please check one of the following:

☐ Home Sleep Study ☐ Polysomnographic evaluation at a sleep disorder center

Sleep Center Name: _____

Sleep Study Date: ____/____/_____

FOR OFFICE USE ONLY

The evaluation confirmed a diagnosis of _____

The evaluation showed:

	during REM		*Supine*	*Side*
an RDI of				
an AHI of				

a nadir SpO_2 of ____ T90 ____ ODI ____ (Oxygen Desaturation Index)

Slow Wave Sleep ☐ Decreased ☐ None

REM Sleep ☐ Decreased ☐ None

Additional Questions

☐ Yes ☐ No Are you a current CPAP (Continuous Positive Air Pressure) user?

If Yes, what are the current CPAP settings: _____

CPAP Intolerance

(Continuous Positive Airway Pressure device)

If you have attempted treatment with a CPAP device, but could not tolerate it please fill in this section:

☐ Refuses CPAP	☐ Noise disturbing sleep and/or bed partner's sleep	☐ Claustrophobic associations
☐ Mask leaks	☐ CPAP restricted movements during sleep	☐ An unconscious need to remove the CPAP
☐ Inability to get the mask to fit properly	☐ CPAP does not seem to be effective	☐ Does not resolve symptoms
☐ Discomfort from headgear	☐ Pressure on the upper lip causing tooth related problems	☐ Noisy
☐ Disturbed or interrupted sleep	☐ Latex allergy	☐ Cumbersome

Patient Signature: _____ Date: _____

CPAP Intolerance

(Continuous Positive Airway Pressure device)

Other

Other Therapy Attempts

include:

- ☐ Dieting
- ☐ Weight loss
- ☐ Surgery (Uvuloplasty)
- ☐ Surgery (Uvulectomy)
- ☐ Pillar procedure
- ☐ Smoking cessation
- ☐ CPAP
- ☐ BiPAP
- ☐ Uvulectomy (but continues to have symptoms)
- ☐ Uvuloplasty (but continues to have symptoms)
- ☐ Positional therapy (side sleeping)
- ☐ Nasal strips

History Of Treatment

Practitioner's Name	Specialty	Treatment	Approximate Date

Sleep History

Previous Diagnosis

Have you been previously diagnosed with Obstructive Sleep Apnea? ☐ Yes ☐ No

If yes, how long ago was it? ☐ *number* ☐ Years ago ☐ Months ago ☐ Days ago

Sleep:

Sleep Onset Latency ☐ minutes

Normally goes to bed at ☐ ☐ AM PM

Hours of sleep per night ☐ hours

☐ Gasping

☐ Getting up <# of times> per night

Sleep Aid ☐ Yes ☐ No

If yes, name the medication:

☐ Bruxism (grinding teeth)

☐ Dry mouth

☐ Excessive movements

Patient Signature:

Date:

Sleep History

Witnessed apneas are:

- ☐ Worse when sleeping on your back
- ☐ Worse following alcohol late at night

Wake

Sleepiness while driving ☐ Yes ☐ No

Risks Discussed ☐ Yes ☐ No

The patient:

- ☐ Awakens unrefreshed
- ☐ Has morning headaches

Naps
- ☐ naps daily
- ☐ never naps
- ☐ occasionally naps
- ☐ _____

Snoring is reported as:

Frequency
- ☐ seldom
- ☐ never
- ☐ daily
- ☐ often
- ☐ nightly
- ☐ _____

☐ Worse when sleeping on your back

☐ Worse following alcohol late at night

Severity
- ☐ light
- ☐ moderate
- ☐ loud
- ☐ _____

Patient Signature

Because of HIPAA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By agreeing to this consent, you permit the release of any information to or from your dental practitioner as required including a full report of examination findings, diagnosis and treatment program to any referring or treating dentist or physician. You understand that you are financially responsible for all charges whether or not paid by insurance. Your dental practitioner may use your health care information and may disclose such information to your Insurance Company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.

Patient Signature: _____ Date: _____

I certify that the medical history information is complete and accurate.

Patient Signature: _____ Date: _____

Medical History Questionnaire

OFFICE USE
Patient ID:____

NAME: _____

FORM DATE: ___/___/_____

DATE OF BIRTH: ___/___/_____

Allergens

- ☐ No known allergens
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local anesthetics
- ☐ Metals
- ☐ Penicillin
- ☐ Plastic
- ☐ Sedatives
- ☐ Sleeping pills
- ☐ Sulfa drugs

Current Medications

Medicine	Dosage/Frequency	Reason

Other

Medical History

Significant	Medical Condition	Current: Never	Current: Past	Date / Note	Significant	Medical Condition	Current: Never	Current: Past	Date / Note
☐	Acid reflux	☐	☐		☐	Blood pressure - Low	☐	☐	
☐	Anemia	☐	☐		☐	Bruising easily	☐	☐	
☐	Atherosclerosis	☐	☐		☐	Cancer	☐	☐	
☐	Arthritis	☐	☐		☐	Chemotherapy	☐	☐	
☐	Asthma	☐	☐		☐	Chronic fatigue	☐	☐	
☐	Autoimmune disorder	☐	☐		☐	Chronic pain	☐	☐	
☐	Bleeding easily	☐	☐		☐	COPD	☐	☐	
☐	Blood pressure - High	☐	☐		☐	Coronary heart disease	☐	☐	

Patient Signature: _____ Date: _____

Medical History

Significant	Medical Condition	Current	Never	Past	Date / Note	Significant	Medical Condition	Current	Never	Past	Date / Note
☐	Current pregnancy		☐	☐		☐	Liver disease		☐	☐	
☐	Depression		☐	☐		☐	Meniere's disease		☐	☐	
☐	Diabetes		☐	☐		☐	Mitral valve prolapse		☐	☐	
☐	Difficulty sleeping		☐	☐		☐	Mood disorder		☐	☐	
☐	Dizziness		☐	☐		☐	Multiple sclerosis		☐	☐	
☐	Emphysema		☐	☐		☐	Muscular dystrophy		☐	☐	
☐	Epilepsy		☐	☐		☐	Nasal allergies		☐	☐	
☐	Excessive Daytime Sleepiness		☐	☐		☐	Neuralgia		☐	☐	
☐	Fibromyalgia		☐	☐		☐	Osteoarthritis		☐	☐	
☐	Glaucoma		☐	☐		☐	Osteoporosis		☐	☐	
☐	Gout		☐	☐		☐	Parkinson's disease		☐	☐	
☐	Heart attack		☐	☐		☐	Prior orthodontic treatment		☐	☐	
☐	Heart murmur		☐	☐		☐	Radiation treatment		☐	☐	
☐	Heart pacemaker		☐	☐		☐	Rheumatic fever		☐	☐	
☐	Heart valve replacement		☐	☐		☐	Rheumatoid arthritis		☐	☐	
☐	Hemophilia		☐	☐		☐	Sinus problems		☐	☐	
☐	Hepatitis		☐	☐		☐	Sleep apnea		☐	☐	
☐	Hypertension		☐	☐		☐	Stroke		☐	☐	
☐	Hypoglycemia		☐	☐		☐	Tendency for ear infections		☐	☐	
☐	Immune system disorder		☐	☐		☐	Thyroid disorder		☐	☐	
☐	Insomnia		☐	☐		☐	Tuberculosis		☐	☐	
☐	Ischemic heart disease (reduced blood supply)		☐	☐		☐	Tumors		☐	☐	
☐	Kidney problems		☐	☐		☐	Urinary disorders		☐	☐	

Other

Medical Condition	Current	Past	Date / Note	Medical Condition	Current	Past	Date / Note
☐	☐	☐		☐	☐	☐	

Patient Signature: Date:

Confidential Medical History

Significant	Medical Condition	Current: Never	Current: Past	Date / Note	Significant	Medical Condition	Current: Never	Current: Past	Date / Note
☐	Recreational drugs	☐	☐						
☐	HIV/AIDS	☐	☐						

Surgical Operations

☐ Appendectomy
☐ Back
☐ Ear
☐ Gallbladder
☐ Heart
☐ Hernia repair
☐ Lung
☐ Nasal
☐ Thyroid
☐ Tonsillectomy
☐ Uvulectomy
☐ Periodontal

Other

Family History

Has any member of your family (parent, sibling, or grandparent) had:

☐ Cancer
☐ Heart disease
☐ Diabetes
☐ High blood pressure
☐ Stroke
☐ Sleep disorder
☐ Obesity
☐ Thyroid disorder
☐ Father snores
☐ Mother snores
☐ Father has sleep apnea
☐ Mother has sleep apnea

Social History

Patient's Occupation

Employer

Tobacco Use: Cigarettes ☐ Never smoked ☐ Current smoker ☐ Quit

# of packs per day

# of years

When did you quit?

Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol Use: Do you drink alcohol? ☐ Yes ☐ No If yes, # of drinks per week:

Caffeine Intake: ☐ None ☐ Coffee/Tea/Soda # of cups per day:

Additional:

☐ Regular exercise

Patient Signature:

Date:

Candlewood Dental Care

Lorraine Burio, DMD

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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. 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 02/12/2003, 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include 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.

Your 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.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, texts, emails, postcards, or letters).

PATIENT RIGHTS

Access: *You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we reserve the right to impose a minimal charge per page for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)*

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but 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.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** 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.

Amendment: You 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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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: Lorraine Burio, DMD **Telephone: (203) 746-1200** **Fax: (203) 746-2315**

E-mail: contactus@mycandlewooddental.com

Address: P.O. Box 8198, 87 State Rte. 39, New Fairfield, CT 06812

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR LORRAINE BURIO, DMD

You May Refuse to Sign This Acknowledgement

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

_____
Please Print Name

_____
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)

_____

_____

_____

CANDLEWOOD DENTAL CARE

INFORMED CONSENT:

It is important to us that you understand the treatment we are recommending and any procedures we may, with your agreement, perform. We want to involve you in all decisions concerning procedures you may need. We want you to understand that there is a risk associated with dental procedures and want to be sure your questions have been answered.

Dental treatment and procedures are not to be taken for granted as being routine or without risk for complications. As with all medical treatment, including dental treatment, there are no guarantees that the results will be as planned. When dealing with the human body there are potentially many variables, some predictable and others are not. Complication rates in dentistry are low but unforeseen complications may arise. Whenever drilling is involved, even a simple, routine procedure can lead to pulpal (nerve) problems, abscess, fractured tooth, and/or post treatment pain to biting or to temperature extremes (hot and cold). It is important that you fill out your medical history as completely as possible and inform your provider of any medical conditions or dental concerns.

I HAVE READ, UNDERSTAND, AND CONSENT TO DENTAL TREATMENTS.

INITIALS:_____ DATE:_____

FINANCIAL POLICY ACKNOWLEDGEMENT:

PATIENTS WITHOUT DENTAL INSURANCE:

We are committed to providing you with the highest quality of care. Our fees are a reflection of the quality of care we provide. We continue our commitment by offering a variety of financial options to enable you to receive the dental care you need. We accept cash, check, VISA, Mastercard, Discover and American Express. We have also partnered with a third-party company, CareCredit, to offer the flexibility of deferred interest and extended payment options. We also offer our in-house discount plan, the Smile Savers Club. We will communicate all recommended treatment options and associated fees, prior to the start of treatment. Payment is expected at the time of treatment.

PATIENTS WITH DENTAL INSURANCE:

We will submit charges and pre-authorizations electronically to your dental insurance. **You will be asked to pay your deductible, your portion of charges, and for non-covered procedures the day treatment is rendered.** We will estimate your responsibility as closely as possible but until we receive insurance payments, it is just an estimate. We will assist you in receiving payment from your insurance; however, **you are responsible to fully satisfy charges regardless of insurance benefits or payments**. It is your responsibility to understand the type of dental insurance you have and the benefits selected by you and/or your employer.

Your signature on this form serves as a Signature on File for your dental insurance, to be used on all insurance submissions, authorizing the release of information to your insurance company, authorizing payment directly to Dr. Burio/Candlewood Dental Care, and authorizing representatives of Candlewood Dental Care to act as your agent in helping your obtain payment from your insurance company.

*** We are committed to respecting your time and ask that you make every effort to keep the appointment time reserved exclusively for you. We understand there may be times when you are unable to keep your scheduled appointment, however, any appointment missed may be subject to a missed appointment fee of **$45 per hygiene appointment and $100 per doctor appointment.** Should you find it necessary to reschedule an appointment, please provide us with a notice of two business days to avoid being charged a missed appointment fee ***

Accounts delinquent 45 days from the date of service will be sent to collections and the outstanding balance will incur an additional 33 1/3 % collection fee plus court and attorney's fees. A delinquent account impedes our ability to provide you with the quality of dental care you deserve. ** If your check is returned for any reason, you will incur a $45 service fee*

***Your signature grants permission to Candlewood Dental Care or its assignee, to telephone you at phone numbers provided to discuss your account or treatment, leave messages on your answering machines, and/or contact you by e-mail or text (unless you have chosen to opt-out of these forms of contact).**

The above policies apply equally to parents and guardians of minors being treated and minors cannot be treated without a parent or guardian authorizing treatment and agreeing to financial responsibility. ***It is our policy that the parent or guardian who accompanies a child to our office for treatment is responsible for payment of all services rendered.**

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL AND OFFICE POLICIES.

_____ Date: _____

Patient Name

_____ Relationship to patient: _____

Signature of Responsible Party

_____

Printed Name of Responsible Party

Rev 11/4/15

Lorraine Burio, DMD
87 Rte. 39, P.O. Box 8198
New Fairfield, CT 06812
Office: (203) 746-1200
Fax: (203) 746-2315

From Waterbury Area:

Take 84 West to Exit 6 in Danbury. Take a RIGHT at end of ramp. At the next light, bear LEFT onto Rte. 37 North (Padanaram Rd.). Go straight through 3 lights. The 4th light will be approximately 5 miles from the 3rd light. At that 4th light, you will be in the center of New Fairfield. Take a RIGHT onto Rte. 39. Go straight through the light at Stop & Shop. In about ½ mile, the road will make a sharp left hand turn. (Green road sign will say Candlewood Corners). Just as the turn starts to straighten out, our office will be on the left. It is a white house with red shutters directly across the street from a Sunoco station. The driveway is just before the motel and you will park and enter in the rear of the building.

From NY Area:

Take 84 East to Exit 5 in Danbury. Go straight through the stop sign to the light at the bottom of the hill. Go straight through that light. Now count 4 lights, at the 4th light, bear LEFT onto Rte. 37 North (Padanaram Rd.) Go straight through 3 lights. The 4th light will be approximately 5 miles from the 3rd light. At that 4th light, you will be in the center of New Fairfield. Take a RIGHT onto Rte. 39. Go straight through the light at Stop & Shop. In about ½ mile, the road will make a sharp left hand turn. (Green road sign will say Candlewood Corners). Just as the turn starts to straighten out, our office will be on the left. It is a white house with red shutters directly across the street from a Sunoco station. The driveway is just before the motel and you will park and enter in the rear of the building.

From 95 NYC Area:

Take 95 South to 287 West to White Plains. Then take 684 North to Exit 9E to 84 East. Follow the above directions from 84 East.

From Stamford, Wilton Area:

Take 95 North to Exit 15 (Rte. 7 North), then Rte. 7 North to 84 East. Follow the above directions from 84 East.

Patient Screening Form

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.