Elmwood Dental

New Patient Registration Form

Employee Initial (for office use only) _____

Patient Information Title: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

First Name:_____ Middle Initial: _____ Last Name:_____

Preferred Name:_____

Address:_____ City:_____ State:____ Zip:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ ☐ You may contact me via text message

E-mail:_____ ☐ You may contact me via e-mail

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

Date of Birth:_____ Social Security #:_____

Employer:_____ Employer Address:_____

Employment Status: ☐ Full time ☐ Part time ☐ Retired Student Status: ☐ Full time ☐ Part time

Primary Care Physician: _____ Phone Number: (____)_____

Primary Dentist (if not our practice): _____ Phone Number: (____)_____

Pharmacy Name and Location: _____ Phone Number: (____)_____

Patient Preferences

Do you prefer ☐ Morning appointments? ☐ Afternoon appointments? ☐ No Preference?

Do you have a preferred Dentist?_____ Hygienist?_____

Referral Information

How did you hear about us? ☐ Internet ☐ TV ad ☐ Radio ad ☐ Dental Implant Seminar ☐ Newspaper ad

☐ Referred by a dentist_____ ☐ Referred by a friend/relative_____

Which dentist were you referred to?_____

Patient Responsibility

Who is responsible for payment on your account? ☐ Self ☐ Spouse ☐ Parent ☐ Other_____

If not yourself: Responsible party's name:_____ Date of birth:_____

Employer:_____ Work phone: (____)_____

Social Security #_____

Billing Address: _____ City:_____ State____ Zip_____

Insurance

Do you have dental insurance? ☐ No ☐ Yes Insurance Co._____

Subscriber:_____ Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other_____

Subscriber's Date of Birth: _____ Subscriber's Address:_____

Policy ID/Social Security#_____ Subscriber's Employer: _____

Do you have secondary dental insurance? ☐ No ☐ Yes Insurance Co._____

Subscriber:_____ Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other_____

Subscriber's Date of Birth: _____ Subscriber's Address:_____

Policy ID/Social Security#_____ Subscriber's Employer: _____

TURN OVER AND FILL OUT REVERSE SIDE

Medical History for_____Patient Name_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medication you may be taking could affect the dental care you will receive. Thank you for answering these questions.

Are you under a physician's care now?..... ☐ Yes ☐ No For what: _____

Have you ever been hospitalized or had a major operation? ..... ☐ Yes ☐ No For what: _____

Have you ever had a serious head or neck injury? ..... ☐ Yes ☐ No Describe_____

Are you taking any medications, pills or drugs? ..... ☐ Yes ☐ No List_____

Do you/have you ever taken Phen-Fen or Redux?..... ☐ Yes ☐ No

Do you/have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No

Are you on a special diet? ..... ☐ Yes ☐ No Describe _____

Do you use tobacco?..... ☐ Yes ☐ No

Do you pre-medicate before your dental appointments? ..... ☐ Yes ☐ No

Women: Are you ☐ Pregnant ☐ Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Local Anesthetics

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Other, please explain: _____

Do you use controlled substances? ☐ Yes ☐ No If yes: _____

Do you/have you ever had the following conditions?

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/gout
- ☐ Artificial heart valve
- ☐ Artificial joint
- ☐ Asthma
- ☐ Blood disease
- ☐ Blood transfusion
- ☐ Breathing problem
- ☐ Bruise easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest pains
- ☐ Cold sores/fever blisters
- ☐ Congenital heart disorder
- ☐ Convulsions
- ☐ Cortisone medicine
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Easily winded
- ☐ Emphysema
- ☐ Epilepsy or seizures
- ☐ Excessive bleeding
- ☐ Excessive thirst
- ☐ Fainting spells/dizziness
- ☐ Frequent cough
- ☐ Frequent diarrhea
- ☐ Frequent headaches
- ☐ Genital herpes
- ☐ Glaucoma
- ☐ Hay fever
- ☐ Heart attack/failure
- ☐ Heart murmur
- ☐ Heart pacemaker
- ☐ Heart trouble / disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High blood pressure
- ☐ High Cholesterol
- ☐ Hives or rash
- ☐ Hypoglycemia
- ☐ Irregular heartbeat
- ☐ Kidney problems
- ☐ Leukemia
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Lung disease
- ☐ Mitral valve prolapse
- ☐ Osteoporosis
- ☐ Pain in jaw joints
- ☐ Parathyroid disease
- ☐ Psychiatric care
- ☐ Radiation treatments
- ☐ Recent weight loss
- ☐ Renal dialysis
- ☐ Rheumatic fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle cell disease
- ☐ Sinus trouble
- ☐ Spina bifida
- ☐ Stomach/intestinal disease
- ☐ Stroke
- ☐ Swelling of limbs
- ☐ Thyroid disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or growths
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Yellow jaundice

Have you ever had a serious illness not listed above? ☐ No ☐ Yes_____

Payment Method (check one)

☐ I have BCBS of Rochester, MetLife or Cigna Dental insurance coverage. Elmwood Dental Group will receive payment directly for my treatment if the treatment is completed by a participating dentist. I will be responsible for any balance not covered by my insurance.

☐ I prefer to pay at each appointment by: ☐ Cash or check ☐ MasterCard ☐ Visa ☐ Discover

☐ Dental insurance benefits will be reimbursed directly to me.

I want to apply for a CareCredit Card to make monthly payments over an extended period of time.

- **To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.**
- Any remaining balance on my account is my responsibility. I agree to pay my balance plus finance charges at the highest level rate and reasonable collection costs and/or attorney fees incurred by Elmwood Dental Group, PC if my balance is not paid.
- I hereby authorize Elmwood Dental Group, P.C. to release any medical or other information necessary to process my insurance claim forms.
- I hereby authorize Elmwood Dental Group, P.C. to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The above information is accurate to the best of my knowledge.

Signed_____Date_____

(parent or guardian, if patient is a minor)

Acknowledgement of Receipt of Notice of Privacy Practices

Elmwood Dental Group P.C.

* You May Refuse to Sign This Acknowledgment*

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

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)

_____

_____

_____

ELMWOOD DENTAL GROUP, PC
ELMWOOD DENTAL RESTORATION AND IMPLANT CENTER
1950/1960 SOUTH CLINTON AVENUE
ROCHESTER, NY 14618
(585) 461-4350 / FAX (585) 461-9365

APPOINTMENT CANCELLATION AND NO SHOW POLICY

At Elmwood Dental we are committed to providing you, our valued patients, with excellent quality and convenient dental services. In that regard, we ask your cooperation by making every effort to keep scheduled appointments. **We ask that you provide at least 24 hours notice for appointment cancellations.**

However, we know that things do come up that make it impossible to keep scheduled appointments (i.e. sickness, transportation problems, and family emergencies). Cancellations due to inclement weather and/or hazardous driving conditions are acceptable. In consideration of our patients and our staff, please call as soon as possible if you know you will be unable to keep a scheduled appointment.
UNEXCUSED ABSENCES ARE ENTIRELY UNACCEPTABLE.

We will charge a fee for no show appointments and repeated cancellations.
This fee will be assessed regardless of insurance type and payment is the responsibility of the patient, not the insurance company.

Fees for missed appointments are as follows:

Hygiene Cancellations / No Show Broken Appointments: $30
Doctor Cancellations / No Show Broken Appointments: $90 per hour

Due to the high volume of Cancellations and No Shows we ask that these fees be paid prior to any further treatment.

I have read and agree to adhere to the above attendance Policy.

Patient Signature: _____ Date: _____

SNORING/ SLEEP APNEA QUESTIONNAIRE

It is estimated that up to 95% of adults with Obstructive Sleep Apnea (OSA) remain undiagnosed and that 25% of men and 9% of women over 40 suffer from the condition. OSA is a chronic condition which profoundly affects a sufferers' quality of life, cognitive, cardiovascular, and metabolic health. Please fill out the following screening questionnaire that we might better identify your risk.

PATIENT'S NAME: _____

TODAYS DATE: _____

Do you or have you ever been told you snore? YES NO

Have you ever been diagnosed with sleep apnea? YES NO **Wear CPAP?** YES NO

Do you often wake up feeling tired and remain tired throughout the day? YES NO

Do you have or take medications to treat any of the following conditions:

High Blood Pressure? YES NO

Diabetes? YES NO

Acid Reflux? YES NO

CLINICAL EXAM TO BE COMPLETED BY DOCTOR OR HYGIENIST

Blood Pressure:

Maxillary/ Mandibular Tori? YES NO

Maxillary Palatal recession or erosion? YES NO

Scalloped Borders of the tongue? YES NO

History of TMJ symptoms / Clenching and Grinding? YES NO

Patient recommended to attend a free seminar or schedule a consultation? YES NO