Wilson Dental, PC (Syracuse)
224 S. Geddes Street
Syracuse, NY 13204
Ph. #: 315.423.9900
Fax #: 607.238-1276

Patient Personal Information

Title _____ Nickname _____ Birth Date ____/____/_____ Age _____

First Name: _____ Last Name:_____ Marital Status:_____ Sex:_____

Address: _____ City_____ State_____

Zip Code _____

Cell Phone # _____ Home Phone #_____

Email _____

Are you referred? _____

Patient Medical History

Allergic to the following?:

Please circle Yes or No

Y N No Known Allergies
Y N Aspirin
Y N Barbiturates / Sleeping Pills
Y N Codeine
Y N Erythromycin
Y N Hydrocodone
Y N Iodine
Y N Latex Rubber
Y N Local Anesthetics
Y N Metals
Y N No Epinephrine
Y N Penicillin
Y N Prior Hepatitis
Y N Sulfa Drugs
Y N Other Narcotics

Do you have any of the following?:

Please circle Y or N

Y N No Change Since Last Recorded
Y N No Know Concerns or Issues
Y N Abnormal Bleeding
Y N ADHD
Y N AIDS/HIV Infection
Y N Alcohol/Drug Abuse
Y N Angina
Y N Anemia
Y N Ankles Swell
Y N Arteriosclerosis
Y N Arthritis
Y N Asthma
Y N Autism
Y N Autoimmune Disease
Y N Bladder Trouble
Y N Blood Clotting Problems
Y N Blood Transfusion
Y N Bronchitis
Y N Bulimia

Y N Cancer / Tumor Growth
Y N Cardiac Pacemaker
Y N Cardiovascular Disease
Y N Chemotherapy
Y N Chest Pain Upon Exertion
Y N Color Blindness
Y N Congenital Heart Defect
Y N Congestive Heart Failure
Y N Contact Lenses
Y N Damaged Heart Valve
Y N Diabetes
Y N Emphysema
Y N Environmental Allergies
Y N Epilepsy
Y N Fainting Spells
Y N Fever Blisters
Y N Frequent Headaches
Y N Frequent Dry Mouth / Sjogren
Y N Gag Reflex
Y N Gall Bladder Trouble
Y N Hay Fever
Y N Heart Attack
Y N Heart Disease
Y N Heart Murmur
Y N Hepatitis
Y N High Blood Pressure
Y N Hives
Y N Jaundice
Y N Kidney Issues
Y N Leukemia
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mental Health Problems
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Persistent Diarrhea
Y N Premedicate
Y N Radiation Treatment
Y N Rheumatic Fever
Y N Rheumatic Heart Disease
Y N Rheumatoid Arthritis
Y N Seizures
Y N Sexually Transmitted Disease
Y N Shortness of Breath
Y N Skin Rash
Y N Sinus Trouble
Y N Stomach Ulcers
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis
Y N Unusual Weight Loss
Y N Urinate Frequently

Other

Y N See Scanned Documents
Y N Dentist Referral

Dental Questionnaire

Dental Questionnaire:
Please circle Yes or No
Name of Previous Dentist _____
Previous Dentist Phone Number _____
Date of your last cleaning _____/ _____/ _____
Last exam date _____/ _____/ _____
Date of your last full series of x-rays _____/ _____/ _____
Date of your last cavity detection (bitewing) x-rays _____/ _____/ _____
Do your gums bleed while brushing or flossing? Yes or No
Are your teeth sensitive to hot, cold, or sweets? Yes or No
Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth? Yes or No
Have you ever had burning of the tongue or cracking of the corners of your mouth? Yes or No
Do you chew and/or smoke tobacco in any form? Yes or No
Have you had any head, neck, or jaw injuries? Yes or No
Do you notice popping, clicking or soreness of the jaws or points just in front of the ears? Yes or No
Do you clench or grind your teeth? Yes or No
Have you ever had orthodontic treatment? Yes or No
If yes, date of placement? _____/ _____/ _____

Do you wear dentures or partials? Yes or No
If yes, date of placement? _____/ _____/ _____
Are you happy with your dentures? Yes or No
Do you have any specific problems with your teeth, gums, or mouth at this time? Yes or No
Are you happy with your smile? Yes or No
Do you have problems with teeth/fillings breaking? Yes or No
Do you regularly use dental floss? Yes or No
Do you have, or have you ever been told that you have Pyorrhea (Periodontal Disease)? Yes or No
Do you have difficulty opening your mouth widely? Yes or No
Do you have an unpleasant taste or odor in your teeth/mouth? Yes or No
Does food catch between your teeth? Yes or No
Do you want to learn to control your dental disease and retain your teeth? Yes or No

Additional Comments

Any disease, condition, or problem not listed? If yes, please list.

_____

Medical Questionnaire

Emergency Contact Information

Emergency Contact Name _____
Emergency Contact Phone Number _____
Emergency Contact Relationship to Patient _____

Medical Questionnaire

Please circle Y or N

Family Physician _____
Family Physician Phone Number _____
Are you currently under the care of a physician? Yes or No
If yes, what is the condition being treated, if any? _____
Have you had any serious illness, operation or been hospitalized within the past 5 years? Yes or No
If yes, what illness, operation, or problem? _____
Are you currently taking any medication? Yes or No
If yes, what are you taking? _____
Have you taken bisphosphonates(Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, or Reclast)? Yes or No
Do you use alcoholic beverages? Yes or No
Do you smoke? Yes or No

Women ONLY

Please circle Yes or No

Are you pregnant? Yes or No
If yes, when are you due? _____/ _____/ _____
Are you currently nursing? Yes or No
Are you on birth control pills / fertility drugs? Yes or No

Additional Comments

Any disease, condition, or problem not list? If yes, please list.

_____

Pharmacy Information:

Pharmacy Name _____

Pharmacy Location - Complete Address _____

Patient/Guardian Signature:_____ **Date:** _____

WILSON DENTAL, PC
EHR "ELECTRONIC HEALTH RECORD"

PLEASE PRINT

Patient's Name_____

Date of Birth: _____

Height: _____FT. _____IN. Weight: _____LB

To access your electronic dental records on our patient portal go to: **YourDentistOffice.com**

Email address: _____

Ethnicity/Race: *Please circle your answer*

ASIAN AMERICAN INDIAN/ALASKIAN NATIVE HISPANIC/LATINO

BLACK/AFRICAN AMERICAN WHITE/CAUCASIAN

OTHER: _____ DECLINE TO SPECIFY

Language: *Please circle your answer*

ENGLISH CHINESE MANDARIN SPANISH KURDISH ARABIC PORTUGUESE

JAPANESE RUSSIAN FRENCH GERMAN VIETNAMESE OTHER_____

Smoking Status: *Please circle your answer*

NEVER SMOKED / FORMER SMOKER: AGE STARTED_____AGE QUIT_____

CURRENT SMOKER: AGE STARTED _____ HEAVY / LIGHT OR MODERATE

Patient or legal guardian's Signature: _____

Date:_____

Wilson Dental, PC

H.I.P.A.A. CONSENT & PHI

"PROTECTED HEALTH INFORMATION" FORMS

Name: _____

Please circle your answer

YES/NO May we contact you at home or work? Please list the phone # we can contact you:

Home /cell#: (___) _____-_____Work#: (___) _____-_____.

YES/NO May we leave a message with a family member?

YES/NO May we mail you a letter or post card in regards to approvals, scheduling or billing?

Initial: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of this office's "Notice of Privacy Practices" & understand that I have the right to opt out of the following: Optional Information Disclosures: by initialing & signing this form you authorize us the consent to use and disclose the information in the manner that is described in the fore-mention notice provided to me.

Please circle your answer

YES/NO Telephone calls containing general information

YES/NO I authorize private dental information to be disclosed to my insurance company as requested.

YES/NO I authorize dental records and dental images/x-rays to be disclosed as considered necessary by my dental provider and this office.

Initial:_____

PHI AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This form is used to obtain authorization to disclose my health/dental information for the treatment and payment purposes to the individuals you designate below.

I give permission to Wilson Dental, PC to discuss and disclose my health/dental information to the individuals listed below to the extent necessary to help with my health/dental care or with my financial payments. I understand I may revoke this authorization in writing at any time.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____Relationship: _____

Patient or legal guardian's Signature: _____ **Date**: _____

Wilson Dental, PC
FINANCIAL POLICY

PATIENT NAME:_____ **DATE OF BIRTH**:_____

PAYMENT: Fees for treatment are due in full and payable at time of service. For your convenience, we honor cash, check, and major credit cards: Discover, MC, Visa & Amer. Express, (HSA) health spending account cards with credit card logos.

INTEREST FREE LINE OF CREDIT: We also accept Care Credit financing which is an interest free line of credit you can apply for in office. You can also call: (800)-365-8295 or go online for an instant decision to: https://www.carecredit.com

MEDICAID & MANAGED CARE: Patients with Medicaid or MMC must present their ID card for eligibility verification and preauthorization before each appointment. You agree to be responsible for any services that you consent to be completed that are not approved or provided by Medicaid or managed care. For all such services payment will be due at time of service.

PAST DUE ACCOUNTS: If either of the above options results in your account becoming 30 days overdue, a finance charge of 1.5% per month will be applied to your account. Should your account be turned over to collection agency or attorney, a 25% collection fee will be added to your account in addition to any other collection fees, court costs, or attorney fees incurred. In case of suit, you agree the venue shall be in Broome County, New York. WAIVER OF CONFIDENTALTY: In any external collection action regarding tour account, your file may be a matter of public record.

RETURNED CHECKS: There is a minimum $25.00 charge for all returned checks. We may increase this fee anytime without prior notice due to bank fees and processing costs.

DENTAL INSURANCE: Insurance policies are contracts between the insurance company and you. It is the policy of your office to make financial arrangements with you directly, since you are responsible for treatment charges. Our office will process a completed insurance form for you to your insurance company. We assume responsibility for the amount of insurance coverage or process of reimbursements.

AUTHORIZATION FOR RELASE OF INFORMATION AND ASSIGNMENT OF BENEFITS:

I authorize Wilson Dental to release to my insurance carrier such protected health/dental information as may be necessary for the completion of my treatment claims, if necessary, assign to Wilson Dental benefits for such claims, and agree to be responsible for any balance remaining after payment of such claims. In consideration for the professional services rendered to me, or at my request, I agree and understand the above, and give my consent for services.

Patient or Legal Guardian's Signature: _____

Date:_____

Wilson Dental, PC
APPOINTMENT CANCELLATION POLICY

POLICY: We have a 24 hour cancellation policy. If you need to change or reschedule an appointment with us, please give us at least ONE BUSINESS DAY notice. Our central scheduling center may be reached at: (607) 217-7123 between the hours of 8am-7pm Monday-Friday and 8am-5pm Saturday and Sundays.

MISSED APPOINTMENTS: If you have two consecutive missed appointments, or have three missed appointments within one year, we reserve the right to dismiss you from our practice. You will also be considered a no show if you cancel or reschedule after you arrive to your appointment.

MULTIPLE APPOINTMENTS: Patients that have multiple family members or multiple appointments on the same day that are cancelled or rescheduled without a 24 hour notice, may not be able to schedule on the same day or together again.

UNCONFIRMED APPOINMENTS: We reserve the right to cancel an appointment that has not been confirmed and ask that you update your contact information regularly.

LATE ARRIVAL: We have a 15 minute grace period for most appointments and if you are late for your appointment we reserve the right to reschedule your appointment for a later time.

Patient or Legal Guardian Signature: _____

Date:_____

WILSON DENTAL

Patient Code of Conduct

Wilson Dental supports the government's "Zero Tolerance" campaign for Health Service Staff. It states that Providers and their staff have a right to care for others without fear of being attacked, abused, or bullied. To be successful in providing these services, a mutual respect between all staff and patients' needs to be in place. Our hardworking staff do their very best to be polite, helpful and sensitive to patients' individual needs. We would respectfully like to remind patients to mind their manners. The staff understands that patient who are in pain do not always act in a reasonable manner and will take this into consideration when trying to deal with a misunderstanding or complaint from a patient.

Wilson Dental takes it very seriously if a member of our staff is treated in an abusive or violent way. Unfortunately, violence towards healthcare workers is all too common in today's society. It all starts with nasty rhetoric and can quickly escalate. Aggressive behavior, be it violent or abusive will not be tolerated and may result in you being discharged from Wilson Dental.

In order for Wilson Dental to maintain good relations with our patients, we would like to ask all patients to read and take note of types of behaviors that we find unacceptable:

- Causing damage to or stealing from Wilson Dental, our staff, or our patients.
- Any physical violence toward any member of the Wilson Dental team or other patients, such as pushing or shoving.
- Using bad language or swearing at office staff
- Racial abuse and sexual harassment will not be tolerated within Wilson Dental.
- Persistent or unrealistic demands that cause stress to staff will not be accepted. Requests will be met wherever possible and explanations will be given to the best of our ability.

Dismissal from Wilson Dental:

It is not unethical for a provider to dismiss a patient for disrespectful or rude behavior which is disruptive to the office. Patients are expected to follow a code of conduct. Disrespectful words or actions are not welcome in a professional practice. The provider has the right to dismiss a patient from Wilson Dental when this type of behavior occurs.

Patient Name (Please Print):_____

Guardian/Patient Signature:_____

Date:_____