

Welcome! So that we may provide you with the best possible care,
Please complete both pages of this registration and health history form.
All information is completely confidential.

SCOTIA GLENVILLE DENTAL CENTER

REGISTRATION FORM

PLEASE BRING YOUR INSURANCE CARD TO YOUR FIRST APPOINTMENT

Today's date:		PLEASE BRING YOUR INSURANCE CARD TO YOUR FIRST APPOINTMENT										
PATIENT INFORMATION												
Patient's last name:			First:		Middle:		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.		<input type="checkbox"/> Miss <input type="checkbox"/> Ms.		Marital status : (circle one) Single / Mar / Div / Sep / Wid	
Cell Phone:		Home Phone:			Work Phone:			Birth date		Sex:	<input type="checkbox"/> M	<input type="checkbox"/> F
Street address					Social Security no.:			E-mail Address:				
P.O. box:			City:			State:		ZIP Code:				
Occupation / Grade:			Employer / School:				Employer phone no.: ()					
Whom May We Thank For Referring You To Our Office?								<input type="checkbox"/> Insurance		<input type="checkbox"/> Family	<input type="checkbox"/> Friend	
<input type="checkbox"/> Co-worker	<input type="checkbox"/> Dr.	<input type="checkbox"/> Public Event Name:			<input type="checkbox"/> Verizon Yellow Pages		<input type="checkbox"/> TransWestern Yellow Pages		<input type="checkbox"/> Ad	<input type="checkbox"/> Sign	<input type="checkbox"/> Close to home/work	
Other Family Members Seen Here:												
BILLING & INSURANCE INFORMATION										(Please give your insurance card to the receptionist.)		
Person Responsible For Bill:				Address (if different):			Birth date:		Home phone no.:			
									()			
Is this person a patient here?	<input type="checkbox"/> Yes		<input type="checkbox"/> No		Patient's relationship to guarantor		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other:		
Employer:		Employer address:			Occupation:			Employer phone no.:				
								()				
Name Of Primary Insurance (if applicable):							Address:			Phone no.:		
Subscriber's name:			Subscriber's S.S. no.:		Birth date:		Group no.:		Policy no.:		Co-payment:	
					/ /						\$	
Patient's relationship to subscriber:			<input type="checkbox"/> Self	<input type="checkbox"/> Spouse		<input type="checkbox"/> Child	<input type="checkbox"/> Other:					
Name Of Secondary Insurance (if applicable):							Address:			Phone no.:		
Subscriber's name:			Subscriber's S.S. no.:		Birth date:		Group no.:		Policy no.:		Co-payment:	
					/ /						\$	
Patient's relationship to subscriber:			<input type="checkbox"/> Self	<input type="checkbox"/> Spouse		<input type="checkbox"/> Child	<input type="checkbox"/> Other:					
IN CASE OF EMERGENCY												
Name of local friend or relative (not living at same address):					Relationship to patient:			Home phone no.:		Work phone no.:		
								()		()		
Address:							Cell phone no.:		E-mail address:			
							()					
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any balance. I also authorize Scotia Glenville Dental Center or insurance company to release any information required to process my claims. I hereby authorize Scotia Glenville Dental Center to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care, and that a consumer report may be requested in connection with credit available. If your account becomes delinquent it may be sent to collection agency for collection. If your account is sent to collection you will be responsible for additional penalties, interest and a collection fee to cover established costs of processing, handling and collecting delinquent debts.												
Patient/Guardian signature								Date				
Relationship to patient:			<input type="checkbox"/> Self		<input type="checkbox"/> Spouse		<input type="checkbox"/> Child		<input type="checkbox"/> Other:			

Name <i>(Last, First, M.I.):</i>		DATE		
Primary Reason for this dental appointment <input type="checkbox"/> EXAM <input type="checkbox"/> EMERGENCY <input type="checkbox"/> CONSULT Explain:				
Previous or referring dentist:		Date of last dental exam:		
List any dental problems that other doctors have diagnosed:				
DENTAL HEALTH HISTORY				
Do you have a specific dental problem? Describe:		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have dental examinations on a routine basis?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Would you describe your present dental health as good? Comments:		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have problems with eating?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you think you have active decay (cavity) or gum disease?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do your gums ever bleed?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you brush and floss on a routine basis? Discuss:		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you feel nervous about having dental treatment?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you ever had a bad experience in a dental office? Describe:		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you want to keep your remaining teeth?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you like your smile?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
MEDICAL HISTORY				
Medical doctor's name:				
Are you under a doctor's care now? Why?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you ever been hospitalized during the past 2 years? Why?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
WOMEN: Are you pregnant? If yes: Gestational Age? _____		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers				
Name the Drug(s):				
Allergies to medications, Name the Drug(s):				
Have you ever been told you need to Pre-medicate for Dental work?		<i>If so, Why?</i>		
Do or Did you smoke?	How many packs a day?	Since when?	Quit When?	
OTHER PROBLEMS				
Circle if you have, or have had, any symptoms in the following areas to a significant degree.				
Heart Trouble	Chest Pain	Scarlet Fever	Cancer	Hypoglycemia
High Blood Pressure	Shortness of Breath	Asthma	Thyroid Disease	Psychiatric Care
Low Blood Pressure	Swelling of feet /ankles/hands	Hay Fever	Parathyroid Disease	Drug Addiction
Heart Murmur	Fainting or Dizziness	Sinus Trouble	X-ray or Cobalt Treatment	Blood Transfusion
Rheumatic Fever	Stroke	Emphysema	Chemotherapy	Hemophilia
Congenital Heart Lesion	Diabetes	Frequent Cough	Radiation	AIDS
Artificial Heart Valve	Excessive thirst	Lung Disease	Arthritis/ Gout	Venereal Disease
Heart Pacemaker	Artificial Joints / Hips	Tuberculosis	Rheumatism	Cold Sores
Heart Surgery	Kidney Trouble	Liver Disease	Pain in Jaw Joints	Fever Blisters
Blood Disease	Ulcers	Hepatitis A (Infectious)	Cortisone Medicine	Herpes
Anemia	Allergies	Hepatitis B (Serum)	Glaucoma	Bruise Easily
Contact Lenses	Nervousness	Yellow Jaundice	Epilepsy or Seizures	Sickle Cell Anemia
Other::				
MEDICAL UPDATES				

I HAVE READ MY MEDICAL HISTORY DATED _____ AND CONFIRM IT ADEQUATELY STATES PAST AND PRESENT CONDITIONS

DATE	EXCEPTIONS	NONE	√	PATIENT SIGNATURE	REVIEWED BY:

Scotia Glenville Dental Center
ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

****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)

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Scotia Glenville Dental Center

REQUEST FOR RELEASE OF PATIENT RECORDS

TO:

Name:
Address
Address

The undersigned acknowledges their lawful authority to request the release of a patient's record. The undersigned and listed patient has hereby requested the transfer of said records and we hereby, request that you release the following patient's records:

Patient's Name: _____

DOB: _____

Address: _____

Authorized Recipient:
Scotia Glenville Dental Center
214 Mohawk Avenue
Scotia, New York 12302
(518) 377-4431

Signature

DATE: _____

Guardian (if applicable)

DATE: _____

We thank you in advance for help and cooperation in this matter.

SCOTIA GLENVILLE DENTAL CENTER



DR. JEFFREY M. BACKER

DR. AMANDA MARX

DR. CARA HERNAS

DR. REBECCA KOEHLER

DR. BURT GOLDFINGER

DR. GREG MORRA

GENERAL PRACTITIONERS

DR. PAUL SHELDON

ORTHODONTIST

**214 MOHAWK AVENUE
SCOTIA, NEW YORK 12302
(518) 377-4431**

Dear New Patient

If you do not know who we are, let us introduce ourselves. We are a group practice of general dentists and specialists whose goals are to provide our patients with prompt, courteous, affordable service and to maintain your mouth in a state of optimum health for life. We provide a full range of dental care for patients of all ages.

The philosophy of this practice is preventative dentistry. Early detection and prompt treatment, along with periodic examinations, cleanings, and fluoride treatments, will help maintain your mouth in a state of optimum health. We are so committed to this philosophy – we are always reminding our patients when they are due for their periodic hygiene appointments.

All patients are entitled to and are provided with a clear explanation of their health status, based on a complete and thorough oral examination. All our patients are given a written treatment plan, showing what treatment has been recommended for them, the cost involved and what insurance benefits are available to them for each procedure. We will be your advocate with your insurance company.

Our practice is able to provide most dental procedures, from preventative (cleaning & exams) to cosmetic services (bleaching & laminates), from restorative (fillings) to major rehabilitation procedures (crowns, implants, bridges, and dentures), from endodontics (root canals) to periodontics (gum disease services) and oral surgery (extractions), not to mention orthodontics for children and adults, and TMJ therapy. This is possible because of the ongoing continuing education the doctors and staff take part in. Continuing education is a top priority and requirement of the dentists and staff of the Scotia Glenville Dental Center.

For your protection, we adhere to infection control procedures known as “universal precautions.” We use the same infection control measures for every patient to prevent transmission of disease. We are always open to discuss our infection control procedures. Please ask us if you have any questions.

We are participating providers with most dental insurances. Early morning and late evening appointments are available to accommodate busy schedules. If you have an emergency, the doctors can always be reached.

It is our goal to make your visit to our office a pleasant experience. We are proud of our facility, co-workers and record of service to the community. We look forward to including you in our tradition of fine dentistry.

Our practice has been growing, and we are grateful to our established patients who have referred their friends and family to us. We appreciate their trust in us.

Communication is important to us – don't be afraid to give us a call to ask questions!

We look forward to seeing you at your appointment and again, we thank you for your vote of confidence.

Sincerely,

Scotia Glenville Dental Center