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

Today's date:	**WE LOOK FORWARD TO SEEING YOU ON:**

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status: (circle one) Single / Mar / Div. / Sep / Wid

Cell Phone:	Home Phone:	Work Phone:	Birth date	Sex: ❑ M ❑ F

Street address	Social Security no.:	E-mail Address:

P.O. box:	City:	State:	ZIP Code:

Occupation / Grade:	Employer / School:	Employer phone no.:
	Email:	( )

Whom May We Thank for Referring You to Our Office:	❑ Insurance	❑ Family	❑ Friend

❑ Co-worker	❑ Dr.	❑ Public Event Name:	❑ Verizon Yellow Pages	❑ TransWestern Yellow Pages	❑ Ad	❑ Sign	❑ 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?	❑ Yes	❑ No	Patient's relationship to guarantor	❑ Self	❑ Spouse	❑ Child	❑ 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:	❑ Self	❑ Spouse	❑ Child	❑ 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:	❑ Self	❑ Spouse	❑ Child	❑ 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:	*❑ Self*	*❑ Spouse*	*❑ Child*	*❑ Other:*

SCOTIA GLENVILLE DENTAL CENTER HEALTH HISTORY FORM

Name *(Last, First, M.I.):*	**DATE**
Primary Reason for this dental appointment ☐ EXAM ☐ EMERGENCY ☐ 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:	☐ Yes	☐ No
Do you have dental examinations on a routine basis?	☐ Yes	☐ No
Would you describe your present dental health as good? Comments:	☐ Yes	☐ No
Do you have problems with eating?	☐ Yes	☐ No
Do you think you have active decay (cavity) or gum disease?	☐ Yes	☐ No
Do your gums ever bleed?	☐ Yes	☐ No
Do you brush and floss on a routine basis? Discuss:	☐ Yes	☐ No
Do you feel nervous about having dental treatment?	☐ Yes	☐ No
Have you ever had a bad experience in a dental office? Describe:	☐ Yes	☐ No
Do you want to keep your remaining teeth?	☐ Yes	☐ No
Do you like your smile?	☐ Yes	☐ No

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: | **Email:**

Home Phone: | **Work Phone:** | **Cell Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks ☐
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

For Office Use Only
BP ☐ Heart Rate: ☐

Height: ☐

Weight: ☐

Y N	Conditions
☐ ☐	Abnormal Bleeding
☐ ☐	Alcohol Abuse
☐ ☐	Allergies
☐ ☐	Anemia
☐ ☐	Angina Pectoris
☐ ☐	Arthritis
☐ ☐	Artificial Heart Valve
☐ ☐	Artificial Joints
☐ ☐	Asthma
☐ ☐	Blood Transfusion
☐ ☐	Cancer- Chemotherapy
☐ ☐	Chest Pain
☐ ☐	Colitis
☐ ☐	Congenital Heart Defect
☐ ☐	Diabetes
☐ ☐	Difficulty Breathing
☐ ☐	Drug Abuse
☐ ☐	Emphysema
☐ ☐	Epilepsy
☐ ☐	Fainting Spells
☐ ☐	Fever Blisters
☐ ☐	Frequent Headaches

Y N	Conditions
☐ ☐	Glaucoma
☐ ☐	HIV+ AIDS
☐ ☐	Hay Fever
☐ ☐	Heart Attack
☐ ☐	Heart Surgery
☐ ☐	Hemophilia
☐ ☐	Hepatitis A
☐ ☐	Hepatitis B
☐ ☐	High Blood Pressure
☐ ☐	Kidney Problems
☐ ☐	Liver Disease
☐ ☐	Low Blood Pressure
☐ ☐	Mitral Valve Prolapse
☐ ☐	Pace Maker
☐ ☐	Pneumocystitis
☐ ☐	Psychiatric Problems
☐ ☐	Radiation Therapy
☐ ☐	Rheumatic Fever
☐ ☐	Seizures
☐ ☐	Shingles
☐ ☐	Sickle Cell Disease
☐ ☐	Sinus Problems

Y N	Conditions
☐ ☐	Stroke
☐ ☐	Thyroid Problems
☐ ☐	Tuberculosis
☐ ☐	Ulcers
☐ ☐	Venereal Disease
☐ ☐	Yellow Jaundice

Y N	Allergies
☐ ☐	Aspirin
☐ ☐	Codeine
☐ ☐	Dental Anesthetics
☐ ☐	Erythromycin
☐ ☐	Jewelry
☐ ☐	Latex
☐ ☐	Metals
☐ ☐	Penicillin
☐ ☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

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}

A copy is available upon your request.

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)

_____

_____

_____

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

_____ DATE: _____
Signature

_____ DATE: _____
Guardian (if applicable)

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

SCOTIA GLENVILLE DENTAL CENTER

DR. JEFFREY M. BACKER
DR. AMANDA MARX
DR. MARTIN STESS
GENERAL PRACTITIONERS

DR. SERGEY BERENSHTEYN
ORTHODONTIST

Dear 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.

214 MOHAWK AVENUE
SCOTIA, NEW YORK 12302
OFFICE (518) 377-4431
Fax (518)377-0415

We are participating providers with most dental insurances. You are responsible for any copayment and /or deductible as required by your insurance company at the time of service. As a courtesy to all patients we will verify your dental insurance benefits, but you are responsible to know your Plan coverage, exclusions and limitations. Your insurance policy is a contract between you and your insurance company. Many insurance policies may have Non-covered benefits; you need to know your plan benefits prior to receiving services. We recommend you contact your insurance company for verification of your policy's benefits. We are not liable to know each and every plans benefits for the hundreds and hundreds of insurance plans on the market.

The estimated amount not covered by your insurance is due at the time of treatment and may be paid by cash, personal check, Visa, or MasterCard. All estimates are subject to final approval by your dental insurance plan; therefore, the amount due is subject to change after final insurance benefits have been paid.

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, this time has been reserved especially for you so we can take care of your dental needs. If you are unable to keep an appointment, please call the office as far in advance as possible. We request at least 2 business days' notice so we can re-schedule the time for another patient. Although we do understand that sometimes situations arise beyond your control, we reserve the right to charge for appointments cancelled or broken without 2 business days' notice.

Again, we thank you for your vote of confidence and allowing us to participate in your dental health care.

Sincerely,

Scotia Glenville Dental Center

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

Fax (518)377-0415