Green Lakes Dental
511 E. Genesee St, Fayetteville, NY 13066
(315) 637 4616
www.greenlakesdental.com

PATIENT INFORMATION

Are you filling this form out for you or someone else?	
First Name	
Last Name	
DOB	
Gender	
SSN (HIPPA encrypted for security purposes)	
Martial Status	
How did you hear about us?	
Who can we thank for referring you?	
Mailing Address (Street)	
City	
State	
Zip Code	
Home Phone	
Mobile Phone	
Is it okay to text appointment reminders	Yes No
Email	
Is it okay to email appointment reminders	Yes No
Do you have an emergency contact?	
Emergency Contact Name	
Emergency Contact Phone Number	

Do you have dental insurance	Yes	No
On this insurance, is the patient the subscriber?	Yes	No
If no, who is the subscriber		
Name of Insurance Company		
Subscriber ID		
Is there a secondary insurance company?	Yes	No
On this 2nd insurance, is the patient the subscriber?	Yes	No
Name of Insurance Company		
Subscriber ID		

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HEALTH HISTORY

NAME:

DOB:

ADDRESS:

Name of Physician, practice and phone number:

Name of any medical specialists you are seeing:

Pharmacy and City/Town:

Are you required to pre-med with antibiotics before dental treatment?

Yes **No**

Please list reason for Pre Med: _____

Do you have a history or are currently being treated for any Heart, Circulatory, Diabetic or BP conditions?

Angina	
Arteriosclerosis	
Artificial Heart Valve	
Cardiovascular Disease	
Congenital Heart Disease	
Congestive Heart Failure (CHF)	
Coronary Artery Disease	
Damaged Heart Valves	
Diabetes	
Heart Arrhythmias	
Heart Attack	
Heart Failure	
Heart Valve Disease	
High Blood Pressure	
Infective Endocarditis	
Low Blood Pressure	
Mitral Valve Prolapse	
Pacemaker	
Peripheral artery disease	
Rheumatic heart Disease	
Vasculitis	

Do you have a history or are currently being treated for any Lung, Breathing or Thyroid conditions?

Acute respiratory distress syndrome	
Asthma	
Bronchitis	
COPD	
Cystic fibrosis	
Emphysema	
Pneumonia	
Pulmonary edema	
Pulmonary emphysema	
Tuberculosis	
Thyroid Disease	

Do you have a history or are currently being treated for any Digestive or Dietary conditions?

Acid reflux/heartburn	
Celiac Disease	
Diverticulitis	
Eating disorder	
Gastrointestinal disease	
GERD	
Lactose Intolerance	
Malnutrition	
Severe or rapid weight loss	
Ulcers	

Do you have a history or are you currently being treated for any Neurological, Seizure, Motor Function conditions?

ALS

Alzheimer's or Dementia

Autism

Brain Aneurysm

Brain Injury

Dementia

Epilepsy

Fainting

Migraines/severe headaches

Multiple Sclerosis

Myasthenia Graves

Parkinson's Disease

Seizures

Stroke

Do you have a history or are you currently being treated for any Autoimmune or Bleeding conditions?

Anemia

Ankylosing Spondylitis

Arthritis

Bleeding Disorder/Hemophilia

Blood thinner use

Diabetes

Graves' disease

Hashimoto's thyroiditis

Immune Deficiency

Lupus

Psoriasis

Rheumatoid Arthritis

Do you have a history or are you currently being treated for Artificial Joint or Artificial Heart Valves?

Artificial Heart Valve?

Artificial Joint?

If you answered yes, are you required to Pre-med?

Do you have a history or are you currently being treated for any forms of Cancer or tumors?

Brain Tumor

Breast Cancer

Cancer

Chemotherapy/Radiation

Liver Cancer

Lung Cancer

Multiple Myeloma

Tumors

Do you have a history or are you currently being treated for any forms of Liver, Kidney or Cholesterol Problems?

Hepatitis

High Cholesterol

Jaundice

Kidney Disease

Liver Disease

Low Cholesterol

Renal/Kidney Problems

Do you have a history of smoking, alcohol, STD/HIV Conditions?

Alcohol use (socially)

HIV/AIDS?

HPV

STD

Tobacco (smoking)

Tobacco (dip/chew)

Are there any other conditions we should be aware of?

MEDICATIONS & ALLERGIES

Are you taking any pain medications?

Acetaminophen

Aspirin

Codeine

Demerol (Meperidine)

Hydrocodone (Vicodin/ Norco)

Ibuprofen

Naproxen

Meloxicam (Mobic)

Motrin

Percocet (Oxycodone)

Ultram (Tramadol)

Are you taking any Diabetes, Cholesterol, or Blood Pressure medications?

Avapro (Irbesartan)

Coreg (Carvedilol)

Crestor (Rosuvastatin)

Klor-Con (Potassium Chloride)

Lasix (Furosemide)

Lipitor (Atorvastatin Calcium)

Lopressor (Metoprolol)

Losartan (Cozaar)

Metformin (Glucophage)

Microzide (Hydrochlorothiazide)

Norvasc (Amlodipine)

Pravachol (Pravastatin)

Prinivil (Lisinopril)

Tenormin (Atenolol)

Toprol XL (Metoprolol)

Tricor (Fenofibrate)

Zestoretic (Lisinopril)

Zocor (Simvastatin)

Are you taking any Antibiotics?

Amoxicillin

Azithromycin

Cephalexin

Ciprofloxacin

Clindamycin

Doxycycline

Levofloxacin

Metronidazole

Tetracycline

Zithromax (Azithroymcin)

Are you taking any Allergy or Asthma medications?

Allegra (Fexofenadine)

Astelin (Azelastine)

Benadryl (Diphenhydramine)

Clarinex

Claritin, Alavert (oratadine)

Flonase (Fluticasoe)

Singulair (Montelukast)

Tavist (Clemastine)

Ventolin (Albuterol Inhaler)

Zyrtec (Cetirizine)

Are you taking any Antidepressants or Anxiety medications?

Adderall

Ambien (Zolpidem)

Celexa (Citalopram)

Cymbalta (Duloxetine)

Effexor (Venlafaxine)

Lexapro (Escitalopram)

Neurontin (Gabapentin)

Oleptro (Trazodone)

Prozac (Fluoxetine)

Wellbutrin (Buproprion)

Xanax (Alprazolam)

Zoloft (Sertraline)

Are you taking any Blood thinners?

Aspirin (81mg)

Aspirin (325mg)

Eliquis

Coumadin (Warfarin)

Plavix (Clopidogrel)

Xarelto

Are you taking any steroid, bone remodeling, Thyroid or reflux medications?

Aclasta/Reclast (Zoledronic Acid)

Boniva

Fosmaax (alendronate)

Medrol (methylprednisone)

Predinisone

Prilosec (omeprazole)

Synthroid (levothyroxine)

Are you currently taking any other medications or dietary supplements not listed? Please list

Have you ever had an allergic reaction to any of the following?

Acetaminophen

Acrylic

Amoxicillin

Aspirin

Azithromycin

Barbiturates

Clindamycin

Codeine

Eggs

Erythromycin

Ibuprofen

Iodine

Latex

Metals

Nuts

Penicillin

Soy

Sulfa Drugs

Sulfa

Tetracycline

DENTAL INFORMATION

What is the reason for your visit?	Exam, cleaning, pain, cosmetic, 2nd opinion
Have you had a bad experience at the dentist?	
Can you provide more detail if so:	
How long has it been since you have seen a dentist?	1 mo. 3 mo. 6 mo. 1 yr. 2 yr. Over 3 yrs.
Have you ever had a bad reaction to dental anesthesia	Yes No
Have you had any complications following dental work	
Are your teeth sensitive to hot or cold	
Do your gums bleed when you floss	
Do you grind your teeth	
Have you ever been diagnosed with periodontal disease?	Yes No
If yes, have you had periodontal treatment/scaling?	Yes No
Do you like your smile?	Yes No
If no, is there something you would like to change or have addressed with the dentist?	

OFFICE POLICIES AND GUIDELINES

CANCELLATION POLICY/ NO SHOW POLICY

Your appointments are very important to the Green Lakes Dental team; these highly prioritized time slots are reserved specifically for your care.

We understand that schedules change and adjustments are necessary; therefore we request at least 48 hours notice if you need to reschedule.

Please understand that when you forget or cancel your appointment without giving enough notice, we miss that opportunity to fill that appointment time, and patients on our waiting list miss that opportunity to receive care.

As a courtesy, we send text and email reminders and confirmations so that you can confirm the date and time of your appointment 5 and/or 3 days prior to your appointment.

Since these services are reserved specifically for you and your care, a cancellation fee may apply if adequate notice is not given. All cancellation fees collected will be donated to the Golisano Children's Hospital

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

INSURANCE: As a non-participating provider, we do not accept payment in full from insurance. We accept payment from insurance, but you, as the patient are responsible for the remaining payment not covered by insurance. Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Again; please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT: Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered not covered by insurance. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

Our office offers a 5% discount on all services if paid in full by CASH or CHECK only. The discount does NOT apply to payments with credit cards.

UNPAID BALANCE:
Balances over 90 days old will be subject to a monthly interest of 1.0% (APR 12%). If payment is delinquent, the patient will be responsible for payment of collection, attorneys fees, and court costs associated with the recovery of the monies due on the account.

By singing below, I have read, understand, and agree to the terms and conditions of this Financial Agreement

Signature: _____

GREEN LAKES DENTAL X RAY GUIDELINES

As your oral health care team, it is our full responsibility to ensure that when you leave our facility, your oral health has been fully assessed and that you have been made aware of any recommended treatment based upon our full diagnostic workup. These diagnostics and our full assessment cannot be completed without all of the required information and this includes dental radiographs.

The standard regimen for taking dental x-rays is as follows:

Full Mouth Series: once every 3-5 years
4 Bitewings and 2PA's: every 1-2 years (taken in between the dates of the FMX.)
PAN: As indicated

As dental professionals we also understand that it is **your decision** on how you would like to proceed. However, because of our dedication to providing you with thorough and comprehensive care we will not waiver from our radiograph policy. **If you elect not to have x rays taken, our team will not be able to provide you with care**. We do not make this decision lightly, but as a team want to make sure we are taking care of our patients to the best of our abilities.

By signing below, I agree to follow Green Lakes Dental, the ADA & FDA's guidelines on recommended x rays.

Signature: _____

PREVIOUS PROVIDERS X RAYS TO BE SENT OVER TO OUR OFFICE
PLEASE READ CAREFULLY

As your new dental provider it is important that we have your **up to date dental radiographs**

Ultimately, it is **YOUR** responsibility to ensure all of your previous radiographs are sent over to our office.

We will provide you with a records release form with specific instructions for you and your previous office to provide us with.

We will request them to send us the following up to date radiographs:
1) Full Mouth Series 2) 4-BW's and 3) Panoramic imaging

If we are UNABLE to receive those x rays prior to your visit, you will have a full mouth series taken at your new patient visit and you will be responsible for the cost.

If you are OVERDUE for a full mouth series (taken every 3-5 years), you will have an FMX series taken in order to provide us with the most up to date information.

By signing below, I understand everything that has been outlined above.

Signature: _____

Acknowledgement of Receipt of Notice of Privacy Practices (HIPPA)
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

- Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.
- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone, text, email or mail) or provide you with information about treatment options or other health- related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your protected health information to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
We will release your protected health information if requested by a law enforcement official for any circumstance required by law. We may release your protected health information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release protected health information to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your protected health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

We may disclose your protected health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your protected health information to federal officials for intelligence and national security activities authorized by law.

We may disclose your protected health information to correctional institutions or law enforcement HIPAA officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security

of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public.
We may release your protected health information for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.
You have certain rights in regards to your protected health information, which you can exercise by presenting a written request:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect and copy your protected health information.
- The right to request an amendment to your protected health information.
- The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices.
We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (tollfree)

By singing below, I have read, understand, and agree to the terms and conditions of this Privacy Policies

Signature: _____