Smiles of Skaneateles
P. Gard Lorey & Sean P. Smith, DDS
1579 Cherry Valley Turnpike
Skaneateles, NY 13152
315-685-5874

Welcome to our practice! We thank you for joining us in caring for your dental health. By becoming our patient, you have created a partnership which we hope will last through the years.

Our partnership is prevention oriented and dedicated to your health. We are committed to providing superior dental care and are proud of our dedication to our patients. Our goal is to help you feel and look your best while focusing on long term dental health.

Enclosed you will find a registration form including a health questionnaire. Please bring these forms completed along with any dental insurance information on your first appointment. A copy of our financial policy explaining payment and insurance procedures is also included for your review.

We invite you to view us online at www.smilesofskaneateles.com. Our website offers important information about our practice and introduces you to our team. If you want to fill out your paperwork prior to your first visit you can do it on our website.

We welcome new patients and appreciate any referrals we might earn. Our practice again welcomes you and looks forward to a long healthy partnership with you and your family and friends.

Sincerely,
P. Gard Lorey & Sean P. Smith & James Wanamaker, DDS,

TIME DATE

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

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

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Emergency Contact

Emergency #

Pets

Hobbies

Vacations

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

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1579 Cherry Valley Turnpike
Skaneateles, NY 13152
Office (315) 685-5874 - Fax (315) 685-1814

Financial Policy

We are committed to providing you with the best possible care. We never want finances to stand in the way of your overall dental health therefore; we have many different payment options. If you have a dental benefit plan, we are anxious to help you receive your maximum allowable benefits but will never base your dental needs or our recommendations on what your benefit plan is willing to cover.

In order to achieve these goals, we need your assistance and understanding of our payment policy.

Payment or co-payment is due at the time services are rendered. We accept cash, checks, Visa, MC, Discover and American Express. We will be happy to process your insurance claim for both your primary and secondary plans providing we have all the information in order to do so.

We will gladly discuss your proposed treatment and answer any questions you may have. You must realize however that:

1. We will be happy to work with your insurance company to obtain maximum benefits. We recommend you arrive at treatment decisions based on what is best for your overall dental health, not solely on what your benefit plan is willing to cover. Remaining balances not covered by your benefit plan are your FULL responsibility.

2. Because insurance policies vary greatly, we can only ESTIMATE your coverage in good faith but cannot guarantee coverage due to the vast amount of insurance companies we deal with and the complexities of contracts. If you would like to know your exact insurance benefit, we will be happy to send a pre-determination of benefits to your insurance company upon your request.

3. While the filing of insurance claims is a courtesy that we extend to our patients, all charges remain your responsibility from the day of services rendered.

We must emphasize that as dental care providers our relationship is with you. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

We will be asking on the day of your appointment for your full payment or co-payment for services rendered, as well as any outstanding balance on your account. For any extensive procedures, we will continue to make financial arrangements prior to the day of service. Please let us know if arrangements need to be made before you come in for your appointment.

On procedures over $1000, a pre-payment courtesy of 5% will be granted to anyone who schedules an appointment for their needed dental care within 48 hours of the recommendation by the doctor and pays in full upon scheduling. Failure to keep this appointment or change it with less than 24 hours' notice will void courtesy and that amount would be re-applied to the account. We also offer a 3% courtesy for any account paid in full on the day of service. Insured patients who wish to take advantage of this courtesy will need to pay us in full, then allow your insurance company to reimburse you directly for their portion of payment.

If the full payment discount is not something you would like to take advantage of, we will work out a payment plan for any major work. For any payment plan to be implemented, 1/3 of the total fees must be put down on the day of service. Payment plan lengths will range from 3 to no longer than 6 months. The only exception would be for orthodontic cases that take 12-24 months for us to complete.

Regarding appointments and service fees, please realize that a specific amount of time is reserved especially for you. If you must change your appointment, we will require at least 24 hours' notice. Also, we reserve the right to charge a returned check fee and well as late fees up to and including, but not limited to: late payment fee, cancellation fee, broken appointment fee, etc.

Our Financial Coordinator will be happy to assist you with any questions you may have. We look forward to seeing you at your next visit.

I have read, understand, and agree to adhere to the above stated policy.

_____ _____

Patient or Responsible Party Signature Date

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

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.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Dental History

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
Please fill out this form completely to help us meet all your dental needs.
If you have any questions, please ask us - we will be happy to help.

Name of Previous Dentist _____ Location _____

What prompted you to leave that practice? _____

		Y	N
1	Do your gums bleed while brushing or flossing?		
2	Are your teeth sensitive to ***hot or cold*** liquids/foods?		
3	Are your teeth sensitive to ***sweet or sour*** liquids/foods?		
4	Do you feel pain to any of your teeth?		
	If yes, please explain		
	_____		
	_____		
5	Do you have any sores or lumps in or near your mouth?		
6	Have you had any head, neck or jaw injuries?		
7	Have you ever experienced any of the following		
	Clicking of your jaw		
	Pain (jaw joint, ear, side of face)		
	Difficulty in opening or closing		
	Difficulty in chewing		
9	Do you clench or grind your teeth?		
10	Do you bite your lips or cheeks frequently?		
11	Have you ever had any prolonged bleeding after extractions?		
12	Have you had any orthodontic treatment?		
13	Do you have or have you ever had Oral Cancer?		
14	Do you wear dentures or partials?		
15	Do you like your SMILE?		
16	What would you like to change about your smile?		
	_____		
17	Date of Last exam with Previous Dentist	_____	
18	Date of Last Dental X-rays	_____	
19	***Have you ever been told that you need to pre-medicate for dental work?***		

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentists to release any information including my diagnosis and any records to facilitate in my or my child's dental care and/or receive reimbursement for any and all services provided.

Signature of Patient (or parent/guardian if minor) _____ Date _____

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 and understand that our office may:
{Please Print Name}

-Contact me in regards to appointments for myself and family
-Share information with insurance companies to submit claims
-Share information with referral sources and specialists

{Please Print Name - Covers Dependent Children} _____

{Date}_____{Signature}_____

I authorize that my health information may be disclosed to the following people for any purpose. {Please List Name/Relationship/Phone Number}_____

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)

Media Release

****You May Refuse to Sign This Acknowledgement****

Authorization:
By my signature below, I affirm, as a patient of Smiles of Skaneateles (the Practice) OR as the parent or legal guardian of a minor child that is a patient of the Practice named above (the "Patient"), that I authorize the Practice: (i) to capture photographic or video images of the Patient (the "Images"); (ii) to reproduce, use, and disclose the Images, with or without the Patient's name; (iii) to publicize the fact that medical services were provided to the Patient; (iv) to reproduce and publish any testimonials the Patient provides regarding the Practice (collectively referred to herein as the "Information"); and (v) to secure copyright registration for any materials that incorporate the Information, at the election and sole expense of the Practice. The authorization is given to the Practice listed above, for disclosures to any persons, without limitation, who may view the Information in printed or digital form in promotional materials including social media or Internet sites.

Purpose:
The purpose of this authorization is to permit the Information, including Images, to be used for education, patient identification, social media, and marketing and I explicitly consent to the use of Information for advertising and marketing activities to promote the Practice. I acknowledge and agree that no compensation will be provided for the use of the Information.

Expiration and Revocability:
If Patient is signing on his or her own behalf, this authorization expires when the Patient informs the Practice that he or she is no longer a patient of the Practice. If Patient is signing on behalf of a minor child, this authorization expires when the Patient reaches the age of majority, but the authorization remains valid for protected health information already used or disclosed until revoked by the Patient who has attained majority. However, I understand that protected health information already used or disclosed prior to any revocation may no longer be protected. I understand that I may revoke this authorization at any time by notifying the Practice by Certified Mail, return receipt requested, but that revocation will only affect uses and disclosures initiated after the date notice is received by the Practice. Upon receipt of the notice of revocation, the Practice will make reasonable efforts to remove protected health information from social media platforms over which it has control, but cannot guarantee removal from all sites. I understand and explicitly acknowledge that the Internet allows for wide sharing and forwarding of information, and that the Practice cannot control all re-disclosure of information.

No Effect on Treatment:
This authorization is voluntary. I understand that the Practice cannot condition treatment of the Patient on whether I sign this Authorization, and that my decision not to sign will not influence or affect the Patient's treatment in any way.

{Date}_____{Signature}_____