

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☐ FemaleMarital 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

Section 3

Employment Status: ☐ Full Time☐ Part Time☐ RetiredStudent Status: ☐ Full Time☐ Part Time

Medicaid ID: _____

Pref. Dentist: _____

Employer ID: _____

Pref. Pharmacy: _____

Carrier ID: _____

Pref. Hyg: _____

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: _____

Smiles of Skaneateles
P. Gard Lorey, DDS & Sean P. Smith, DDS, PC
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	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problem	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
						Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> 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? | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> |
| 2 Are your teeth sensitive to hot or cold liquids/foods? | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> |
| 3 Are your teeth sensitive to sweet or sour liquids/foods? | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> |
| 4 Do you feel pain to any of your teeth?
If yes, please explain | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> |
-

- | | | |
|--|---|---|
| 5 Do you have any sores or lumps in or near your mouth? | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> |
| 6 Have you had any head, neck or jaw injuries? | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> |
| 7 Have you ever experienced any of the following | | |
| Clicking of your jaw | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> |
| Pain (jaw joint, ear, side of face) | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> |
| Difficulty in opening or closing | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> |
| Difficulty in chewing | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> |
| 9 Do you clench or grind your teeth? | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> |
| 10 Do you bite your lips or cheeks frequently? | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> |
| 11 Have you ever had any prolonged bleeding after extractions? | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> |
| 12 Have you had any orthodontic treatment? | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> |
| 13 Do you have or have you ever had Oral Cancer? | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> |
| 14 Do you wear dentures or partials? | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> |
| 15 Do you like your SMILE? | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> | <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> |
| 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?**

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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

P. Gard Lorey & Sean P Smith, DDS, PC
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}

I authorize that my health information may be disclosed
to _____ for any purpose.

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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