Blount General Dentistry
9651 Brewerton Rd., PO Box 189, Brewerton, NY 13029 (315) 676-7900 (315) 676-7108 fax

Patient name_____ Date:_____

Reason for today's visit:_____

Name of previous dentist:_____
Date and reason of last dental visit:_____
Date of last xrays:_____

Please check any areas of concern:

____bad breath	____grinding teeth	____sensitivity to hot/cold
____bleeding gums	____loose teeth	____ sensitivity to sweets
____broken fillings	____popping of jaw	____sensitivity when biting
____sores in mouth	____food getting stuck between teeth	

Please explain any areas of concern:_____
_____

How often do you brush:_____
How often do you floss:_____

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PATIENT CANCELLATION, NO SHOW, and CONDUCT POLICY

Blount General Dentistry providers are dedicated to ensuring your dental care needs are met in a quality setting. We make every attempt to schedule your visit at a time that is convenient to you. Unfortunately, some patients don't keep their appointment and do NOT notify the office in a timely manner to cancel or reschedule. This results in wasted appointment time when other people who need care could have been seen. **Patient is responsible to contact office to confirm all appointments** at least 24 hours prior to appointment time.

Therefore, patients who abuse their appointment schedule or fail to comply with other criteria as listed below will no longer be considered patients at any Blount General Dentistry office. As per the patient cancellation, no show, and conduct policy for Blount General Dentistry ; patients will be discharged under the following criteria. A letter will be composed and sent via certificate of mailing to notify patient of discharge. A copy of the letter and receipt will be kept in patient record.

- Appointments missed without at least 24 hour advance notice
    - A no show appointment (failure to show or cancelled with less than 24 hours' notice) will be charged a $75 no show fee which is not billable to insurance. (unless prohibited contractually by insurance carrier)
- If not compliant with needed treatment after two instances of patient education
- There is a serious breach of patient/provider relationship
- If you or a family member is verbally abusive or displays inappropriate behavior; including but not limited to, vulgar/profane language or any threatening language or behavior toward any of our team members or other patients
- Inappropriately seeking controlled medications

If there are occasions when you must cancel or reschedule an appointment, please make every attempt to contact Blount General Dentistry at least 24 hours in advance in order to allow another patient to be seen during that time period.

Please sign below indicating you have read and understand this policy.

Extenuating circumstances will be taken into consideration by our practice manager.

_____ _____

Patient signature Date

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THIS OFFICE IS DEDICATED TO THE RETENTION AND RESTORATION OF THE NATURAL DENTITION. THE RESPONSIBILITY FOR THE TREATMENT AND KEEPING SCHEDULED APPOINTMENT LIES WITH THE PATIENT.

***APPOINTMENTS:** Your appointment time is reserved for your dental wellness. We refuse to pass the cost of broken appointments on to others; therefore it is mandatory that all appointments be kept. We will be enforcing a cancellation policy. Please refer to the cancelation policy form for the guidelines. This is to protect all patients from unreasonable fees.

***PRIVACY:** Health related information will remain private except for use as needed for treatment, payment and healthcare operations. A copy of the complete policy is available upon request.

***FINANCIAL RESPONSIBLILTY:** We charge what we have determined to be reasonable fees for the professional services we provide. WE request payment by cash, check, or credit card at the time services are rendered. Any payment plans are done through CARE CREDIT for patients who qualify. Applications can be completed and processed in our office at the time of service.

***INSURANCE:** Dental insurance is a contract between an individual and an insurance company. It is a method of payment, not a method of treatment. The basic responsibility for payment of dental fees belongs to the patient. We will gladly submit claims to your insurance company for you at no charge. We try our best to accurately estimate copays for services; however, we cannot be liable for any charges not covered in full under your particular plan.

If you wish to submit your own claims, we will provide you with any information your insurance company requires. Please note that when submitting your own claims, payment in full will be due at the time services are rendered.

We are happy to preauthorize major procedures so that you are aware of out of pocket costs to treatment being rendered.

I have read and agree to all the above policies

_____ _____

Signature Date

9651 Brewerton Rd., Brewerton, NY 13029 (315)676-7900 (315)676-7108 fax

Acknowledgement of Receipt of Notice of Privacy Policies
And
Consent for Disclosure of Treatment, Payment and Operations

By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office as described in the notice.

_____ _____

Patient/Parent or Legal guardian Date

_____

Print Name of Patient(s)

Please select one

_____ The person(s) indicated below may have full access to my protected health information, including but not limited to, diagnosis, lab tests, prognosis, treatment and billing for all conditions **OR**

____ Disclose my health record, as above, **BUT DO NOT** disclose the following (check appropriate):

Communicable diseases (**including HIV and AIDS**) _____

Alcohol/drug abuse treatment _____

Other (**please specify**) _____

This authorization shall be effective until (Check One)

_____ All past, present and future; _____ Date or event: _____

_____ Until I revoke it. **(NOTE: You may revoke this authorization in writing at any time by notifying your Health Care Providers.)**

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Consent for Restorations (Fillings)

What is a restoration / filling and what are its benefits?

When a tooth has sustained an area of decay or breakage, it can be repaired by a number of restorative options such as amalgam ("silver filling"), gold or porcelain inlay, or composite / resin.
An amalgam filling is a silver material that is retained physically within the tooth by how the tooth is prepared. A composite filling is a white or tooth-colored material that when used with an adhesive agent can bond to a tooth. By placing a composite filling a damaged tooth can be repaired with the intent to regain function and to some degree esthetics.

What are its risks?

1. Sensitivity of Teeth: Often after preparation of teeth for the placement of any restoration, the prepared teeth may exhibit sensitivity. The sensitivity may be mild to severe. The sensitivity may last only for a short period of time or may last for much longer periods of time. If such sensitivity is persistent or lasts for much extended periods of time, I agree to notify the dentist as this may be a sign of more serious problems.

2. Risk of Fracture: Inherent in the placement or replacement of any restoration is the possibility of the creation of small fracture lines in tooth structure. Sometimes these fractures may not be apparent at the time of removal of tooth structure and/or the previous filling and placement or replacement, but may manifest at a later time.

3. Need for Root Canal: Teeth after being filled may develop a condition known as pulpitis or pulpal degeneration. This happens approximately 5% of the time. Every effort is made by the dentist to reduce this from happening, but since teeth contain vital tissue the pulp may become irreversibly inflamed. This may even occur when the tooth had no previous history of being sensitive. Should a root canal become necessary the procedure and any additional procedures (build up, post/core, and a crown) and their fees are additional charges.

4. Esthetics or Appearance: Effort will be made to closely approximate the natural tooth color. However, since a synthetic material is being used to replace natural enamel and dentin, there may not be an exact match. Also, over a period of time, the composite fillings, because of saliva, different foods or drinks consumed, smoking, etc. may cause the shade to change. The dentist has no control over these factors.

5. Breakage, dislodgment or bond failure: Due to biting pressures or other traumatic forces, it is possible for fillings to be dislodged or fractured. The resin-enamel bond may fail, resulting in leakage and recurrent decay. Routine cleaning, exam, and necessary x-rays can help to detect this at an early stage. The dentist has no control over these factors.

6. New Technology and Health Issues: Composite resin technology continues to advance and some fillings may have to be replaced by better, improved materials over time. Some patients believe that having metal fillings replaced with composite fillings will improve their general health. This notion has not been proven scientifically and there are no promises or guarantees that the removal of silver fillings and the subsequent replacement with composite fillings will improve, alleviate, or prevent any current or future health condition.

What are my alternatives?

As stated above, multiple filling materials exist such as amalgam or composite. They all have benefits and risks. As always, choosing not to have treatment is an option but does carry negative consequences such as progressing decay, weakening of tooth structure, future pain and discomfort,

food impaction, and eventual loss of teeth.

INFORMED CONSENT: I can read and write English and have been given the opportunity to ask any questions regarding the nature and purpose of the proposed treatment and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired and/or any results from the treatment to be rendered to me. The fee(s) for these services have been explained to me and I accept them as satisfactory. By signing this form, I am freely giving my consent to authorize the doctors and staff at Blount General Dentistry involved in rendering any services they deem necessary or advisable to treatment of my dental conditions, including the administration and/or prescribing of any anesthetic agents and/or medications.

Anesthetic: The use of local anesthetic is used for pain control during dental procedures. There are inherent risks and side effects. They include, but not limited to: swelling, bruising, soreness, elevated blood pressure or pulse, allergic reaction, and altered sensation that may lead to self-injury. Partial or complete numbness may linger after the dental appointment. In rare cases it can last for an extended time and potentially it can be permanent.

Guarantees: The practice of dentistry is not an exact science and no procedure is 100% successful. The doctors and/or staff at Blount General Dentistry have made no guarantees of a successful outcome.

Notifications: If a patient develops a problem it is the patient's responsibility to notify the doctors and/or staff of Blount General Dentistry. Through this notification we will be able to act on the patient's behalf. Attempts to correct a problem may occur at our office or a referral to another health care practitioner may be warranted.

Patient's name(s) (please print) _____

Signature of patient/legal guardian _____Date_____

Signature of Blount General Dentistry representative _____Date

_____

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
☐ ☐	Colitis
☐ ☐	Congenital Heart Defect
☐ ☐	Cosmetic Surgery
☐ ☐	Diabetes
☐ ☐	Difficulty Breathing
☐ ☐	Drug Abuse
☐ ☐	Emphysema
☐ ☐	Epilepsy
☐ ☐	Fainting Spells
☐ ☐	Frequent Headaches
☐ ☐	Glaucoma

Y N	Conditions
☐ ☐	HIV+ AIDS
☐ ☐	Hay Fever
☐ ☐	Heart Attack
☐ ☐	Heart Surgery
☐ ☐	Hemophilia
☐ ☐	Hepatitis A
☐ ☐	Hepatitis B
☐ ☐	Hepatitis C
☐ ☐	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)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices Acknowledgement could not be obtained because:

- € Individual refused to sign
- € Communications barriers prohibited obtaining the acknowledgment
- € An emergency situation prevented us from obtaining acknowledgement
- € Other (Please Specify)

_____

_____

_____

_____