FAMILY DENTAL WELLNESS
Complete Health Dentistry
BOLAND DENTAL, PLLC
Jordan Boland, DDS
Bernard Schneider, DDS
716-373-1210

Welcome!

Please don't hesitate to ask if you have any questions (716) 373-1210

Dental Registration and History

1. PATIENT INFORMATION

Patient Name _____
Last Name First Name Middle Initial

Date _____ Birthday _____

SSN # _____ Sex ☐ M ☐ F

Address _____

City _____ State _____ Zip _____

Home Tel _____ Work Tel _____

Cell # _____ Occupation _____

Email _____

Marial Status _____ Referral Source _____

How would you like to receive billing statements?

☐ Mail ☐ Email ☐ Text

2. EMPLOYER/SCHOOL

Employer/School Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

Notes _____

3. EMERGENCY CONTACT

Emergency Contact Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Relationship _____

4. INSURANCE INFORMATION

Subscriber/Guarantor Name _____

Birthday _____ SSN _____

Relationship to Patient _____

Insurance Company _____

ID # _____ Group # _____

Other Coverage ☐ Yes ☐ No

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assigned directly to Dr. _____ all insurance benefits. If any charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature _____ Date _____

Even if you don't carry any dental insurance, please sign the above statement.

5. DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____ Telephone _____ Last X-Ray Date _____

Last Cleaning _____ Last Dental Visit _____

Do you feel pain ☐ Yes ☐ No If yes, please describe _____

Do you feel numbness, swelling, or any other sensitivity? ☐ Yes ☐ No If yes, please describe _____

_____

Additional comments about your past dental history _____

_____

Please continue to 2nd page

Medical History

Although dental personnel primarily treat the area 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.

Name: _____ **Phone:** _____ **Date of last medical exam:** _____

What was the exam for? _____ **Current Physician:** _____

	Y	N
Have you ever been hospitalized or had a major operation?	☐	☐
Are you under the care of a physician?	☐	☐
Have you ever had a serious head or neck injury?	☐	☐
Are you taking any medications or supplements?	☐	☐
If yes please list, the dose and how often:		
(use back of paper if needed)		
Do you take or have you taken Phen-Fen or Redux?	☐	☐
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐	☐
Are you on a special diet?	☐	☐
Do you use Tobacco?	☐	☐
Do you use controlled substances?	☐	☐

Women	Y	N
Are you pregnant or trying to get pregnant?	☐	☐
Are you taking contraceptives?	☐	☐
Are you nursing?	☐	☐

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Penicillin
- ☐ Local Anesthetics
- ☐ Acrylic
- ☐ Codeine
- ☐ Metal
- ☐ Latex
- ☐ Sulfa Drugs
- ☐ Other

CHECK ALL THAT APPLY:

FAMILY HISTORY UNKNOWN? ☐ **YES** ☐ **NO**

	HAVE	HAD	FAMILY HISTORY
Acid Reflux	☐	☐	☐
AIDS\HIV Positive	☐	☐	☐
Alzheimers Disease	☐	☐	☐
Anaphylaxis	☐	☐	☐
Anemia	☐	☐	☐
Angina	☐	☐	☐
Arthritis\Gout	☐	☐	☐
Artificial Heart Valve	☐	☐	☐
Artificial Joint:	☐	☐	☐
What Joint? _____			
When? _____			
Asthma	☐	☐	☐
Blood Disease	☐	☐	☐
Blood Transfusion	☐	☐	☐
Breathing Problem	☐	☐	☐
Bruise Easily	☐	☐	☐
Cancer	☐	☐	☐
Type? _____			
Chemotherapy	☐	☐	☐
When? _____			
Chest Pains	☐	☐	☐
Cold Sores\Fever Blisters	☐	☐	☐
Congenital Heart Disorder	☐	☐	☐
Convulsions	☐	☐	☐
Cortisone Medicine	☐	☐	☐
Diabetes	☐	☐	☐
Drug Addiction	☐	☐	☐
Dry Mouth	☐	☐	☐
Easily Winded	☐	☐	☐
Emphysema	☐	☐	☐

	HAVE	HAD	FAMILY HISTORY
Epilepsy\Seizures	☐	☐	☐
Excessive Bleeding	☐	☐	☐
Excessive Thirst	☐	☐	☐
Fainting Spells\Dizziness	☐	☐	☐
Frequent Cough	☐	☐	☐
Frequent Diarrhea	☐	☐	☐
Frequent Headaches	☐	☐	☐
Genital Herpes	☐	☐	☐
Glaucoma	☐	☐	☐
Hay Fever	☐	☐	☐
Heart Attack\Failure	☐	☐	☐
Heart Murmur	☐	☐	☐
Heart Pace Maker	☐	☐	☐
Heart Trouble\Disease	☐	☐	☐
Hemophilia	☐	☐	☐
Hepatitis A	☐	☐	☐
Hepatitis B or C	☐	☐	☐
Herpes	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Hives or Rash	☐	☐	☐
Hypoglycemia	☐	☐	☐
Inflammatory disease	☐	☐	☐
Type? _____			
Irregular Heartbeat	☐	☐	☐
Kidney Problems	☐	☐	☐
Leukemia	☐	☐	☐
Liver Disease	☐	☐	☐
Low Blood Pressure	☐	☐	☐
Lung Disease	☐	☐	☐

	HAVE	HAD	FAMILY HISTORY
Mitral Value Prolapse	☐	☐	☐
Osteoporosis	☐	☐	☐
Pain in Jaw Joints	☐	☐	☐
Parathyroid Disease	☐	☐	☐
Psychiatric Care	☐	☐	☐
Radiation Treatments	☐	☐	☐
When? _____			
Recent Weight Loss	☐	☐	☐
Renal Dialysis	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Rheumatism	☐	☐	☐
Scarlet Fever	☐	☐	☐
Shingles	☐	☐	☐
Sickle Cell Disease	☐	☐	☐
Sinus Trouble	☐	☐	☐
Sleep Apnea	☐	☐	☐
Did you wear a c-pap?	**Y** ☐		**N** ☐
Spina Bifida	☐	☐	☐
Stomach\Intestinal Disease	☐	☐	☐
Stroke	☐	☐	☐
Swelling of Limbs	☐	☐	☐
Thyroid Disease	☐	☐	☐
Tonsillitis	☐	☐	☐
Tuberculosis	☐	☐	☐
Tumors or Growths	☐	☐	☐
Ulcers	☐	☐	☐
Venereal Disease	☐	☐	☐
Yellow Jaundice	☐	☐	☐

HAVE EVER HAD ANY SERIOUS ILLNESS NOT LISTED ABOVE? ☐ **YES** ☐ **NO**

If yes, please explain: _____

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 patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____ **Date:** _____

FAMILY DENTAL WELLNESS
Complete Health Dentistry
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OFFICE POLICY DECLARATION FORM

Family Dental Wellness Team of qualified dentists, hygienists and other support personnel hope to provide you and your family with quality dental care for years to come. Our goal is to educate all of our patients that your mouth "talks" to your body and your body "talks" to your mouth. In order for us to accomplish this task, it is necessary that we also have the utmost cooperation of our patients to ensure their dental health does not become compromised. Our trained team will treat you and your family in the most professional manner and will always be willing to answer any questions you may have regarding your treatment or our office policies. To accomplish this goal, a number of polices have now been implemented to help us serve you best and ensure better overall patient care. We ask that you take a few minutes to review just a couple of these changed policies.

INSURANCE AND PAYMENT FOR SERVICES: We are primarily a " fee-for-service" dental practice. However, we also accept patients who participate in a variety of dental insurance plans as well as patients who have no dental insurance at all. **The only dental insurance we're currently in network with is CSEA. As a courtesy, we can submit claims to most other insurances on the patient's behalf even if we're out of network.** Regardless of a patient's insurance status, the **fees associated with any treatment will be due and expected at the time of service.** As a courtesy, we will make an honest effort to give those patients with insurance coverage an *estimate* of what they can expect their insurance to pay. The amount which is not covered by insurance will be expected to be paid by the insured at the time service is rendered. If for whatever reason an insurance company declines to cover the cost of treatment rendered in our office, **the patient will be responsible for the outstanding balance.** Although we will make every *reasonable* effort to obtain insurance benefits from the insurer, **the ultimate responsibility falls upon the patient to resolve the dispute with their insurance company.**

SCHEDULED APPOINTMENTS: Patients' scheduled appointments are just that – **scheduled** appointments! We make every effort to arrange a convenient time for our patients to attend to their dental needs. In an effort to remind patients of their appointments, an appointment card is given, as well as a courtesy phone call and text are sent. Preferably, our office would like *48 hours notice* if you are unable to keep your scheduled appointment. **At minimum, we require 24 hours notice.** In the event our patients are unable to give proper notice (at least 24 hours) we reserve the right to implement a **$80.00** charge to offset the overhead cost. We prefer not to charge this fee. A simple phone call by you, the patient, will relieve you of this finance and will allow our office to fill the opening with a patient in need of immediate dental care. Thank you in advance for your understanding.

PAYMENT: Our office accepts VISA, Mastercard, Discover, American Express and Care Credit credit cards for payment. We also accept cash and personal checks. As a patient you have the responsibility to attend to your dental needs both at our office and at home. Neglecting your dental needs can and surely will lead to greater complications. Our office will advise our patients of the recommended course of treatment-it is the patient's ultimate decision, however, whether or not he/she wishes to participate in this course of treatment.

I ACKNOWLEDGE I HAVE READ AND REVIEWED THE ABOVE POLICIES OF FAMILY DENTAL WELLNESS.

DATED:_____ SIGNATURE_____

Current Medication List

Name_____

Date of Birth _____

Allergies_____

- Please complete all the information below regarding ALL medications you are currently taking, including any herbals or supplements.

Medications	**Dosage**	**How Often**	**Reason**	**Pharmacy Name and Phone Number**