Portville Dental

"Creating Naturally Beautiful Smiles"

Dr. Bryan D. Petryszak

Patient Information

Date: _____

Name you prefer to be called: _____

Soc.Sec.# _____ / _____ / _____

Patient Name: _____
Last Name

_____ _____
First Name MI

Address: _____

City: _____ State: _____ Zip: _____

Sex: Male ◯ Female ◯ Age: _____

Date of Birth: _____

Married ◯ Widowed ◯ Single ◯ Minor ◯

Separated ◯ Divorced ◯ Partnered ◯

Occupation: _____

Patient Employer/School: _____

Employer/School Address: _____

_____

Employer/School Phone: (_____) _____

Spouse's Name: _____

Birthdate: _____

Soc. Sec. # _____ / _____ / _____

Spouse's Employer: _____

How Did You Hear About Us? _____

Dental Insurance

Who is responsible for this account: _____

Relationship to Patient: _____

Birth date: _____ SS#: _____

Insurance Co. _____

Group #: _____

Is patient covered by additional dental insurance: ◯Yes ◯No

If Yes, please fill in the additional insurance information

Subscriber's Name: _____

Birth date: _____ SS#: _____

Relationship to Patient: _____

Insurance Co.: _____

Group #: _____

Insurance Waiver

Welcome to our practice. Our wish is to be sure your visit meets your expectations in every way. With this, we want to be sure you understand the involvement (or not-involvement) of your insurance for your care today.

1. Dental procedures are not covered under MOST medical insurance policies. MEDICARE DOES NOT COVER SERVICES RELATING TO TEETH.
2. We do not participate in all managed care plans. It is your responsibility to inquire as to the status of our participation with your plan.
3. You are directly responsible for any co-pay as regulated by your insurance company.
4. PLEASE UNDERSTAND ALL ACCOUNTS ARE PAYABLE WITHIN 60 DAYS FROM THE SERVICE DATE. We file all claims as a courtesy, however, it is your responsibility to be sure your insurance has paid their portion of this bill to us.

PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext._____ Cell (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you: _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name: _____ Relationship: _____

Home: (_____) _____ Work (_____) _____ Ext. _____ Cell: (_____) _____

DENTAL HISTORY

Reason for today's visit: _____

_____

Former Dentist: _____

City/State: _____

Date of last dental x-rays: _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad Breath..... ◯Yes ◯No

Bleeding Gums..... ◯Yes ◯No

Blisters on lips or mouth..... ◯Yes ◯No

Burning sensation on tongue..... ◯Yes ◯No

Chew on one side of mouth..... ◯Yes ◯No

Cigarette, pipe, or cigar smoking..... ◯Yes ◯No

Clicking or popping jaw..... ◯Yes ◯No

Dry mouth..... ◯Yes ◯No

Fingernail biting..... ◯Yes ◯No

Food collection between teeth..... ◯Yes ◯No

Foreign objects..... ◯Yes ◯No

Grinding teeth..... ◯Yes ◯No

Gums swollen or tender..... ◯Yes ◯No

Jaw Pain or tiredness..... ◯Yes ◯No

Lip or cheek biting..... ◯Yes ◯No

Loose teeth or broken fillings..... ◯Yes ◯No

Mouth Breathing..... ◯Yes ◯No

Mouth pain, brushing..... ◯Yes ◯No

Orthodontic treatment..... ◯Yes ◯No

Pain around ear..... ◯Yes ◯No

Periodontal treatment..... ◯Yes ◯No

Sensitivity to cold..... ◯Yes ◯No

Sensitivity to heat..... ◯Yes ◯No

Sensitivity to sweets..... ◯Yes ◯No

Sensitivity to biting..... ◯Yes ◯No

Sores or growths in your mouth..... ◯Yes ◯No

How often do you floss _____ ◯Yes ◯No

How often do you brush _____ ◯Yes ◯No

OVER

Health History

Physician's Name: _____ Phone No.(_____)_____ Date of last visit: _____

AIDS/HIV ___Yes ___No	Fainting or Dizziness ___Yes ___No	Respiratory Disease ___Yes ___No
Alzheimers/Dementia ___Yes ___No	Glaucoma ___Yes ___No	Rheumatic Fever ___Yes ___No
Arthritis, Rheumatism ___Yes ___No	Headaches ___Yes ___No	Scarlet Fever ___Yes ___No
Artificial Heart Valves ___Yes ___No	Heart Murmur ___Yes ___No	Shortness of Breath ___Yes ___No
Asthma ___Yes ___No	Heart Problems ___Yes ___No	Sinus Trouble ___Yes ___No
Back Problems ___Yes ___No	Hepatitis - Type_____ ___Yes ___No	Skin Rash ___Yes ___No
Bleeding abnormally, with extractions ___Yes ___No	High Blood Pressure ___Yes ___No	Special Diet ___Yes ___No
Blood Disease/Hemophilia ___Yes ___No	Jaundice ___Yes ___No	Stroke ___Yes ___No
Cancer ___Yes ___No	Jaw Pain ___Yes ___No	Swollen Feet or Ankles ___Yes ___No
Chemical Dependency ___Yes ___No	Kidney Disease ___Yes ___No	Thyroid Problems ___Yes ___No
Chemotherapy ___Yes ___No	Liver Disease ___Yes ___No	Tonsillitis ___Yes ___No
Circulatory Problems ___Yes ___No	Low Blood Pressure ___Yes ___No	Tuberculosis ___Yes ___No
Congenital Heart Lesions ___Yes ___No	Mitral Valve Prolapse ___Yes ___No	Tumor or growth on head or neck ___Yes ___No
Combination of "fen-phen" ___Yes ___No	Nervous Problems ___Yes ___No	Ulcer ___Yes ___No
Cortisone Treatments ___Yes ___No	Pacemaker and/or Defibulator ___Yes ___No	Venereal Disease ___Yes ___No
Cough, persistent or bloody ___Yes ___No	when was pacemaker placed_____	Weight loss, unexplained ___Yes ___No
Diabetes ___Yes ___No	Is pacemaker shielded? ___Yes ___No	
Emphysema ___Yes ___No	Psychiatric Care ___Yes ___No	
Epilepsy ___Yes ___No	Radiation Treatment ___Yes ___No	

Do you snore? ___Yes ___No Have you experienced apnea events during sleep? ___Yes ___No Do you have daytime sleepiness? ___Yes ___No

Do you have hypertension? ___Yes ___No Do you have sleep apnea? ___Yes ___No Do you use a **CPAP** machine? ___Yes ___No

WOMEN ONLY:

Are you pregnant? ___Yes ___No If so, How many weeks_____ Due Date _____

Are you nursing? ___Yes ___No Are you taking birth control pills? ___Yes ___No

MEDICATIONS:

Do you take any medication for osteoporosis? ___Yes ___No

If so, please list medication: _____

List any medications/and or herbal supplements you are currently taking and the correlating diagnosis:

_____

_____

_____

_____

_____

Pharmacy Name: _____

ALLERGIES: If none, please check here: _____

Are you allergic to any of the following:

___ Aspirin ___ Local Anesthetic

___ Barbiturates (Sleeping Pills) ___ Penicillin

___ Codeine ___ Sulfa

___ Iodine ___ Other _____

___ Latex _____

_____

_____

_____

ASSIGNMENT, CONSENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with _____
Name of Insurance Company(ies)
and assign directly to Dr. Bryan D. Petryszak all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance forms. I was informed by Dr. Bryan D. Petryszak, by persons on his staff of the following information in relation to my oral treatment needs: **(1) Treatment alternatives (2) Advantages of each alternative (3) Disadvantages of each alternative (4) Risks, if present (5) Relative costs of each alternative (6) Result of doing no treatment at all.** Understanding this, I hereby authorize the above-named dentist or qualified staff members to accomplish such treatment for me. The above-named dentist(s) 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. I have received a copy of this office Notice of Privacy Practice.

PAYMENT IS EXPECTED THE DAY OF THE APPOINTMENT

At my appointment(s) I will be paying by CASH _____ CHECK _____ CREDIT CARD _____

X_____ _____ X_____

Signature of Patient, Guardian, or Personal Representative — Date — Relationship to Patient

Welcome to Portville Dental, PLLC

149 South Main Street

Portville, New York 14770

1) ABOUT YOUR CHILD

Name: _____
LAST FIRST MID

Name preferred to be called: _____ Age: ____

Birthdate: _____/_____/_____ ☐Male ☐Female
MONTH DAY YEAR

Social Security # : _____

Home Address: _____
POST OFFICE BOX OR STREET ADDRESS

_____
CITY STATE ZIP CODE

Home Phone: _____

2) PERSON RESPONSIBLE FOR CHILD

Your Name: _____

Date of Birth: _____

Social Security # : _____

Relationship to child: _____

Your home phone and address if different from child's:

_____

_____

Occupation: _____

Employer: _____

Work Phone: _____

3) INSURANCE

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE FORMS.

DENTAL INSURANACE COMPANY #1

Dental Insurance Co.: _____

Their Phone # : _____

Group # : _____

This Dental Insurance is provided through:

Their Name: _____

Relationship to Child: _____

Their Social Security # : _____

Their Birthdate: _____

Their Employer: _____

DENTAL INSURANACE COMPANY #2

Dental Insurance Co.: _____

Their Phone # : _____

Group # : _____

This Dental Insurance is provided through:

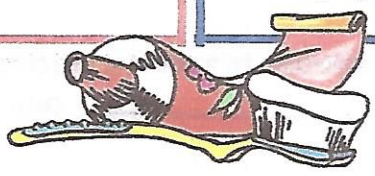
Their Name: _____

Relationship to Child: _____

Their Social Security # : _____

Their Birthdate: _____

Their Employer: _____



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Dental/Medical History

4)

Has your child been to the dentist before? ☐ Yes ☐ No

If yes, the approximate date of last visit: _____

Are there any dental problems that you are aware of at present? ☐ Yes ☐ No

If yes, please explain: _____

Does your child brush his/her teeth daily? ☐ Yes ☐ No

Is your child currently under the care of a physician? ☐ Yes ☐ No

Child's physician: _____

Their Phone # : _____

The approximate date of last visit: _____

Is your child allergic to any drugs? ☐ Yes ☐ No

If yes, please list: _____

Is your child taking any prescription drugs? ☐ Yes ☐ No

If yes, please list: _____

Does your child need to be premedicated before dental treatment? ☐ Yes ☐ No

5)

Has your child ever had any of the following medical conditions or problems?

Please Circle

Y N	Heart Murmur	Y N	HIV+/AIDS
Y N	Heart problems of any kind	Y N	Hemophilia
Y N	Convulsions/Epilepsy	Y N	Bleeding problems of any kind
Y N	Cancer	Y N	Hearing impairment
Y N	Diabetes	Y N	Hyperactive
Y N	Rheumatic Fever	Y N	Any operations
		Y N	Any stays in hospital

Are there any other medical conditions or problems relating to your child? ☐ Yes ☐ No

If yes, please list: _____

6)

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT? Name: _____ Relationship: _____

Phone #'s: _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my childs medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

Signature of parent or guardian: _____ Date: _____