Welcome

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

Patient # _____
SS#/SIN _____
Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Email _____ Cell Phone _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If Student, Name of School/College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time
Patient or Parent/Guardian's Employer _____ Work Phone _____
Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone _____
Driver's License# _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____ SS#/SIN _____
Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local# _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group# _____ Policy/ID# _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local# _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group# _____ Policy/ID# _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Do you have or have you had any of the following?		

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____		
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other _____	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
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?	☐	☐
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 problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement _____	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

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 dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X _____

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments _____

_____

_____ Signature _____ Date _____

NOTICE OF PRIVACY POLICY
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996
HIPAA

PATIENT AUTHORIZATION FORM

I hereby authorize and acknowledge that I have read and understand the HIPAA Privacy Policy. Any questions have been answered to the best of the Privacy Officer's knowledge. I may receive a paper copy of the Privacy Policy if I do so request.

Patient Name:_____

Minor Family members of above patient:

_____

_____

_____

_____

Signature:_____

Relationship of any listed Family Members:_____

Date: _____/_____/_____

DR. CHRISTOPHER T. PAWELEK
6100 ROUTE 31
P.O. BOX 1822
CICERO, NEW YORK 13039
(315) 699-2685

NOTICE OF PRIVACY PRACTICES

This statement describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- *Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- *Payment* means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization reviews. An example of this would be sending a bill for your visit to your insurance company for payment.
- *Health Care Operations* include the business aspects of running our practice, such as condition quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You make revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive, inspect, and copy confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to receive an accounting or disclosures of protected health information.
- The right to obtain a paper copy of this notice upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protect health information.

This notice is effective as of April 1, 2003 and we are required to abide but he terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

DR. CHRISTOPHER T. PAWELEK
6100 ROUTE 31
CICERO, NEW YORK 13066
(315) 699-2685

Christopher T. Pawelek, D.D.S.

6100 Route 31
P.O. Box 1822
Cicero, New York 13039
315-699-2685

____ Information below provided for your office
____ Request the following information from your office

Patient: _____

Last Appointments

Prophy	_____	**Full Series Xrays**	_____
Fluoride	_____	**Bitewings**	_____
Restorative	_____	**Panoramic**	_____

Records Release

Name and address of former dentist: _____
_____
_____
_____

I, _____, authorize the release of my (and/or family's) dental records to/from Dr. Christopher Pawelek, DDS.

Signature: _____ **Date:** _____

Thank you.

Additional family members:

Patient: ____
Last Appointments:

Prophy	____________	Full Series Xrays	____________
Fluoride	____________	Bitewings	____________
Restorative	____________	Panoramic	____________

Patient: ____
Last Appointments:

Prophy	____________	Full Series Xrays	____________
Fluoride	____________	Bitewings	____________
Restorative	____________	Panoramic	____________

Patient: ____
Last Appointments:

Prophy	____________	Full Series Xrays	____________
Fluoride	____________	Bitewings	____________
Restorative	____________	Panoramic	____________

Patient: ____
Last Appointments:

Prophy	____________	Full Series Xrays	____________
Fluoride	____________	Bitewings	____________
Restorative	____________	Panoramic	____________

Patient: ____
Last Appointments:

Prophy	____________	Full Series Xrays	____________
Fluoride	____________	Bitewings	____________
Restorative	____________	Panoramic	____________

Christopher T. Pawelek, DDS
6100 Route 31
Cicero, NY 13039

We sincerely feel that our patients deserve from us the very best dental care that we can provide. Further we feel that everyone benefits when definite financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our financial policy.

Financial Policy Of This Office:

We are a participating provider with Blue Cross and Blue Shield, Delta Dental, Metlife, EBS, Cigna PPO, United Concordia.and Pomco. Under contractual agreement, we will submit for services rendered and bill the patient for services not covered. For extensive treatment, we will submit for pre-authorization of dental benefits prior to beginning treatment and paid for by the patient at time of service.

For patients with other dental insurance or no dental coverage, payment is due on the day of service. We will submit electronically, when applicable, the dental claim and the patient will be reimbursed directly from the dental company.

We accept cash, checks, Visa, Mastercard, Discover card, and Care Credit. Your financial commitment helps us to achieve our goal of quality care for our patients.

Please sign below and return with your Medical History Form.

I HAVE READ THE ABOVE STATEMENT AND AGREE TO THE TERMS STATED:

SIGNATURE:_____

DATE:_____/_____/_____