UPD DENTAL ASSOCIATES

University Pediatric Dentistry

Thank you for selecting University Pediatric Dentistry/UPD Dental Associates.
We strive to make each of your visits pleasant and comfortable.
Please fill out this form completely in ink.

***Please share with us how you were referred:_______________________________Today's date: ___________**
***Name of person completing this form:___________________________________ Relationship:___________**

Patient Information			
Last name:	First name:		Middle initial:
Birthdate: Month:	Day:	Year:	
Social security number:			Sex: ☐ Male ☐ Female
Patient's home address:			
City:	State:	Zip:	Home #: Cell #:

Responsible Party			
Last name:	First name:		Middle initial:
Relationship: ☐ Mother ☐ Father ☐ Legal custodian		Birthdate:	
Social security number (required):	Driver's license number:		State:
Address (if different from patient info above):			
City:	State:	Zip:	
Home #:	Cell#:	Opt out of text messages ☐	Email:
Emergency contact information: Name:		Phone number:	

Pharmacy Information	
Pharmacy name:	Pharmacy phone number:
Pharmacy address:	

Primary Dental Insurance		
Insured person name:	Relationship to patient:	
Social security number:	Birthdate:	
Employer:	Insurance ID #:	
Insurance company:		Group #:
Insurance company address:		
City:	State:	Zip:

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Dental History

Previous dentist:			Phone:
Address:			
City:	State:	Zip:	
Date of last dental visit:			
Were x-rays taken?	☐ Yes Type:		☐ No
Has this patient had difficulty with previous dental visits?	☐ Yes Please explain:		☐ No
Are you aware of any problems with this patient's mouth or teeth?	☐ Yes Please explain:		☐ No
Has this patient ever pre-medicated for dental treatment?	☐ Yes Please explain:		☐ No
Has this patient injured head, mouth, or teeth?	☐ Yes Please explain:		☐ No
Has this patient ever developed any condition including bleeding, drug, anesthesia reaction, or rash requiring special treatment after a dental visit?	☐ Yes Please explain:		☐ No

For Patients Under 18 Only

Question	Yes	No
Does your child take fluoride supplements?	☐ Yes	☐ No
Is your child's water fluoridated?	☐ Yes	☐ No
Does your child suck his/her thumb/finger?	☐ Yes	☐ No
Does your child suck/bite his/her lip?	☐ Yes	☐ No
Does your child bite/chew his/her nails?	☐ Yes	☐ No
Does your child chew hard objects?	☐ Yes	☐ No
Does your child grind his/her teeth?	☐ Yes	☐ No

Medical History (Confidential)

Physician's name:	Phone number:	
Date of last visit:		
Previous hospitalizations/surgeries/serious illnesses and when:		
Is this patient taking any medications?	☐ Yes Which ones:	☐ No
Is this patient allergic to any medications?	☐ Yes Which ones:	☐ No
Is this patient pregnant?	☐ Yes What trimester:	☐ No
Has this patient had a blood transfusion?	☐ Yes When:	☐ No
Are immunizations up to date?	☐ Yes	☐ No

Please check whether any of the disorders/conditions listed below apply to this patient.

Respiratory Diseases/Lung Disorders				Blood Disorders			
Asthma	☐Yes ☐No	Persistent Cough	☐Yes ☐No	Anemia	☐Yes ☐No	Von Williebrand	☐Yes ☐No
Difficulty Breathing	☐Yes ☐No	Shortness of Breath	☐Yes ☐No	Hemophilia	☐Yes ☐No	Sickle Cell	☐Yes ☐No
COPD	☐Yes ☐No	Sleep Apnea	☐Yes ☐No	Excessive Bleeding	☐Yes ☐No	Other:	
If yes, please explain:				If yes, please explain:			

Infectious Diseases				Cancers			
HIV/AIDS	☐Yes ☐No	STI	☐Yes ☐No	Chemotherapy	☐Yes ☐No	Leukemia	☐Yes ☐No
Hepatitis	☐Yes ☐No	Tuberculosis	☐Yes ☐No	Radiation	☐Yes ☐No	Remission	☐Yes ☐No
Herpes	☐Yes ☐No			Tumors	☐Yes ☐No	How long?	
If yes, please explain:				If yes, please explain:			

Stomach Problems				Ear Problems			
Reflux	☐Yes ☐No	Ulcers	☐Yes ☐No	Ear Tubes	☐Yes ☐No	Ear Infections	☐Yes ☐No
If yes, please explain:				Hearing Loss	☐Yes ☐No	Other:	
				If yes, please explain:			

Heart Conditions				Allergies			
Artificial Valve	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Dye	☐Yes ☐No	Milk	☐Yes ☐No
Congenital Heart Defect	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Latex	☐Yes ☐No	Environmental	☐Yes ☐No
Heart Murmur (Irregular Heart Beat)	☐Yes ☐No	Heart Attack (Myocardial Infarction)	☐Yes ☐No	Gluten	☐Yes ☐No	Seasonal	☐Yes ☐No
Heart Disease	☐Yes ☐No	Pacemaker	☐Yes ☐No	Other:			
Rheumatic Fever	☐Yes ☐No	Infective Endocarditis	☐Yes ☐No	If yes, please explain:			
Angina (Chest Pains)	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No	**History of any conditions listed below?**			
If yes, please explain:				Arthritis/Rheumatism	☐Yes ☐No	Liver Disease	☐Yes ☐No
Special Needs				Cleft Palate	☐Yes ☐No	Skin Rash	☐Yes ☐No
ADHD	☐Yes ☐No	Wheelchair	☐Yes ☐No	Diabetes	☐Yes ☐No	Seizures	☐Yes ☐No
Behavior Disorder	☐Yes ☐No	Multiple Sclerosis	☐Yes ☐No	Dialysis	☐Yes ☐No	Sinus Problems	☐Yes ☐No
Autism	☐Yes ☐No	Head Injury	☐Yes ☐No	Epilepsy	☐Yes ☐No	Stroke	☐Yes ☐No
Depression	☐Yes ☐No	Developmental Challenges	☐Yes ☐No	Dizziness/Fainting	☐Yes ☐No	Tobacco Use	☐Yes ☐No
Down Syndrome	☐Yes ☐No	Nervous Disorders	☐Yes ☐No	Joint Replacement	☐Yes ☐No	Drug Use	☐Yes ☐No
Cerebral Palsy	☐Yes ☐No	Psychological Disorders	☐Yes ☐No	Kidney Disease	☐Yes ☐No	Eating Disorder	☐Yes ☐No
Vision Impairment	☐Yes ☐No	Bipolar Depression	☐Yes ☐No	Thyroid Disorder	☐Yes ☐No		
If yes, please explain:				If yes, please explain:			
Anything not previously listed?			☐Yes ☐No	If yes, please explain:			

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(Revised 3/2016)

AUTHORIZATION FOR CARE & TREATMENT: I hereby agree that University Pediatric Dentistry, P.C./UPD Dental Associates, P.C. may perform care and treatment and may conduct examinations, laboratory tests and procedures (including x-rays), administer local anesthetics, analgesia, medication and treatment, as may be directed by the treating practitioner. I acknowledge that no guarantees have been made to me as to the effect of such examinations, tests, procedures or treatment of the condition.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his/her staff responsible for any errors or omissions that I have made in the completions of this form.

INSURANCE AUTHORIZATION: I understand that I am responsible for knowing the terms and conditions of my insurance coverage. I further understand that I may be responsible for obtaining prior authorization for certain services in order for my insurance company to pay for those services, and I understand that I may be personally responsible for payment if I do not obtain any necessary prior authorization, or my insurance benefits are denied, reduced, or terminated.

ASSIGNMENT OF BENEFITS, INSURANCE PROCEEDS & SETTLEMENTS: If I am entitled to health care services under any insurance policy from any person or organization which may become liable to me to provide such benefits, I assign such benefits to University Pediatric Dentistry, P.C./UPD Dental Associates, P.C. and practitioners employed by the practice who render such services. I further authorize payment directly to University Pediatric Dentistry, P.C./UPD Dental Associates, P.C. and such practitioners of all insurance benefits payable. Insurance may include, but is not limited to, private commercial insurance, auto liability insurance, worker's compensation, programs such as Medicare and Medicaid, or other government sources.

I certify that the information given regarding my insurance is accurate and current to the best of my knowledge. I further assign to University Pediatric Dentistry, P.C./UPD Dental Associates, P.C. any payments for medical benefits payable to me as a result of any settlement or judgment in a lawsuit.

CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices (Notice) before you decide to sign this Consent. Our Notice provides a description of the uses and disclosures we may make of your Protected Health Information (PHI), and of other important matters about your PHI. A copy of our Notice accompanies this Consent. We encourage you to read it carefully before signing. We reserve the right to change our privacy practices as described in the Notice. If we change our privacy practices we will issue a revised notice, which will contain the changes. Those changes may apply to any of your PHI that we maintain. You may obtain a copy of our Notice, including any revisions, by contacting:

Name:	Roseann McAnulty	Address:	University Pediatric Dentistry
Telephone:	(716) 688-7712		1800 Maple Road
E-mail:	rmcanulty@updwny.com		Williamsville, NY 14221

Purpose of Consent: This consent does not relieve University Pediatric Dentistry, P.C./UPD Dental Associates, P.C. of its legal obligations to provide you with a copy of the Notice and attempting to obtain your signature on an Acknowledgement. This Consent is not an authorization to use your PHI for purposes beyond treatment, payment, or health care operations.

Right to Object: You have the right to request that we restrict how your PHI is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to your restrictions, but if we do agree, we are bound by the instructions.

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or continue treating you if you revoke this Consent.

FINANCIAL AGREEMENT: In consideration for services rendered by University Pediatric Dentistry, P.C./UPD Dental Associates, P.C. and practitioners employed by University Pediatric Dentistry, P.C./UPD Dental Associates, P.C., I guarantee prompt payment of all services not paid by insurance carriers or third parties within thirty (30) days. I understand that any amount not covered by my insurance carrier or other third party payer is my personal responsibility, and I agree to make payments for any such amount. If University Pediatric Dentistry, P.C./UPD Dental Associates, P.C. does not receive payment within thirty (30) days from the date the balance is due, the bill may be turned over to an attorney or a collection agency, and if so, I agree to pay all reasonable collection cost including attorney's fees and/or collection fees in addition to the payment owed. I give University Pediatric Dentistry, P.C./UPD Dental Associates, P.C. the right to examine my consumer credit report for financial information in relation to my responsibility to pay for dental/medical services.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received the University Pediatric Dentistry, P.C./UPD Dental Associates, P.C. Health Notice of Privacy Practices. A copy is available upon request.

PHOTOS AND VIDEO: Please note, to protect the privacy of our staff and other patients, we would ask that you refrain from taking any forms of photography or videography in our offices. Should you like a photo of your visit to the dentist, please ask a staff member. He/she will attempt to accommodate your request.

DISCLOSURE TO FAMILY OR FRIENDS INVOLVED IN MY CARE: I understand that I may limit the disclosure of health information to family members, or other close relatives or close personal friends by notifying a member of the staff assigned to care for me.

I have read all the above statements and accept the terms and conditions as stated. 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, insurance coverage, and familial status.

______________________	______________________	__________
Patient Name (Print)	**Patient/Parent/Agent/Guardian (Signature)**	**Date**
______________________	______________________	
Parent/Agent/Guardian (Print)	**Relationship to Patient**	
______________________	______________________	__________
Interpreter	**Witness**	**Date**