New Patient Registration

Willam E. Zugner, D.D.S., Todd R. Pedersen, D.D.S., P.L.L.C.
55 North Ave., Webster, NY 14580
Email: northavexrays@gmail.com
Office Phone- (585) 872-2797 Office Fax- (585) 872-5571

First Name: _____ Last Name: _____

Preferred Name: _____ DOB: _____ SSN: _____-_____-_____

Gender: ☐ Male ☐ Female ☐ Unspecified

Address: _____

Cell Phone: _____ ☐ Yes, send me Text Message alerts

Home Phone: _____ Work Phone: _____Ext #: _____

Email: _____ ☐ Yes, send me Email alerts

Emergency Contact: _____ Phone #: _____

Previous Dental Office: _____ Approximate Last Visit: _____

How did you hear about us?

☐ live/work in the area ☐ Google ☐ Social Media
☐ I was referred by: _____ ☐ Other: _____

Dental Insurance Information:

Please bring a copy of your insurance card so we can scan it into your file.

☐ No Dental Insurance

Primary Insurance:

Insurance Company: _____ Employer: _____
☐ Policy Holder ☐ Dependent; Policy Holder: _____ DOB: _____

Relationship to Subscriber: ☐ Spouse ☐ Child ☐ Other:_____

Member ID/ SS#: _____ Group #: _____

Secondary Insurance:

Insurance Company: _____ Employer: _____
☐ Policy Holder ☐ Dependent; Policy Holder: _____ DOB _____

Relationship to Subscriber: ☐ Spouse ☐ Child ☐ Other: _____

Member ID/ SS#: _____ Group #: _____

Patient/Responsible Party:

Print: _____ **Date:** _____

Signature: _____

Medical History2(Copy)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and 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, c

Are you under a physician's care now? If Yes Physician Name:	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	If yes
Do you use tobacco or do you vape?	Yes No	If yes
Have you had an artifical joint/Hip/Valve replaced? If so when?	Yes No	If yes
Do you have to premedicate before a dental appointment? If so for what, and what medication do you take?	Yes No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

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

Other allergies? ☐ If yes

Do you use controlled substances? Yes No If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No	Alzheimer's Disease	Yes No
Diabetes	Yes No	Hepatitis A	Yes No	Anaphylaxis	Yes No	Drug Addiction	Yes No
Hepatitis B or C	Yes No	Renal Dialysis	Yes No	Anemia	Yes No	Herpes	Yes No
Rheumatic Fever	Yes No	Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Hypoglycemia	Yes No	Sickle Cell Disease	Yes No	Asthma	Yes No	Fainting Spells/Dizziness	Yes No
Irregular Heartbeat	Yes No	Sinus Trouble	Yes No	Blood Disease	Yes No	Kidney Problems	Yes No
Blood Transfusion	Yes No	Leukemia	Yes No	Eating Disorder	Yes No	Breathing Problems	Yes No
Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No	Bruise Easily	Yes No
Low Blood Pressure	Yes No	Swelling of Limbs	Yes No	Cancer	Yes No	Lung Disease	Yes No
Thyroid Disease	Yes No	Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No
Tonsillitis	Yes No	Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Convulsions	Yes No
Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No	Blood Thinner	Yes No
Auto Immune Disease	Yes No						

Have you ever had any serious illness not listed above? Yes No If yes

If you are using Oral Contraceptives, it is important that you understand that antibiotics and some other medicines may interfere with the effectiveness of oral contraceptives. Therefore,you will ne

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.

Signature of Patient, Parent or Guardian:

X _____ Date:_____

DENTAL RECORDS RELEASE FORM

Willam E. Zugner, D.D.S., Todd R. Pedersen, D.D.S., P.L.L.C.
55 North Ave., Webster, NY 14580
Email: northavexrays@gmail.com
Office Phone- (585) 872-2797 Office Fax- (585) 872-5571

_____
Date

_____
Patient Name

_____ _____
Date of Birth Phone Number

_____
Previous Dentist/Practice Name

I hereby give permission to release any and all relevant dental records/x-rays to Zugner & Pedersen Dental Group.

Please forward all information to:
northavexrays@gmail.com

_____
Patient Signature (*parent if minor*)

_____
Relationship to Patient (*if applicable*)

FINANCIAL AND CANCELLATION OFFICE POLICIES

Willam E. Zugner, D.D.S., Todd R. Pedersen, D.D.S., P.L.L.C.
55 North Ave., Webster, NY 14580

Our Policies have been set up to prevent misunderstandings. Please initial below each policy. If you have any questions regarding the below information, please contact the office.

Financial Policy:

We accept cash, checks, all major credit cards and offer Cherry Financing & CareCredit.

1. Payment is expected in full at the time of service unless other arrangements have been made.
2. A service fee of 2.0% per month will be applied towards unpaid balances after 90 days.
3. Returned checks are subject to a $25 service charge.
4. Failure to communicate an overdue balance may result in your account being turned over to a collection agency. The patient is responsible for all fees/costs associated with the collection process.

Initial: _____

Insurance:

We participate with Excellus BCBS, Cigna PPO, and UNUM dental insurance.

Your dental insurance contract is an agreement between you and your insurance company. We will process all insurance claims as a courtesy, but the patient or guardian is responsible for understanding their dental insurance eligibility and benefits. We recommend asking for a predetermination of benefits prior to any basic/major dental work. This is only submitted upon the patient's request and we cannot guarantee that any coverage estimated by your plan will be paid once a claim is filed.

Any remaining balance after your insurance has paid is your responsibility.

Initial: _____

Cancellation Policy:

Failure to provide 24hr notice of cancellation may result in a charge. This fee must be paid prior to rescheduling your appointment.

A. $50 per hygiene appointment
B. $75 per ½ hour with the doctor

***If you are more than 15min late, your appointment will automatically be marked as missed and will need to be rescheduled.**

THE DOCTORS RESERVE THE RIGHT TO DISMISS YOU FROM OUR PRACTICE AFTER 3 OR MORE MISSED/CANCELLED APPOINTMENTS

Initial: _____

Please print and sign below to indicate that you have read and fully understand the above policies:

Print Name: _____

Signature: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS FORM AFTER YOU SIGN IT.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Willam E. Zugner, D.D.S., Todd R. Pedersen, D.D.S., P.L.L.C.
55 North Ave., Webster, NY 14580
Office Manager- Molly McCartan
Office Phone- (585) 872-2797 Office Fax- (585) 872-5571
Email- mmccartan@northavedental.com

TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

Purpose of Consent:
By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices:
You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions, by contacting:

Office Manager:	Molly McCartan
Phone:	(585) 872-2797
Fax:	(585) 872-5571
Email:	mmccartan@northavedental.com

Signature:
I have had the full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Patient Name:_____

Signature:_____

If this Consent is signed by a personal representative or on behalf of the patient, complete the following:

Representatives Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT FORM AFTER YOU SIGN IT.