Dear prospective patient,

Welcome, and thank you for choosing the Stony Brook School of Dental Medicine Dental Care Center.

Attached you will find the required paper work for your Program Selection Appointment.

Please complete all forms and bring them with you to your appointment.

Most appointments are one hour, however some can take longer.

When you come to the Dental Care Center on your appointment date please be sure to bring with you:

- Your photo ID
- Your insurance card(s)
- A list of all your medications

If you are the legal guardian or guarantor please bring the legal documents with you at the time of appointment.

The charge for this appointment is $46.00 payable by cash, credit card, or money order, and is due at the time of the appointment.

Thank you and welcome!

The Office of Clinical Affairs

Stony Brook
School of Dental Medicine

Ins:__________
Evd:__________

Demographic:
CHART #______________
Veteran, Gold Star Parent:
Yes No

Patient Information (please print) Date: ___________

Circle One: Mr. Mrs. Miss Ms. Other______________ Circle One: Male Female Other

Name: ______________________________ Date of Birth______________________

Complete Address: ____

____

Telephone including Area Code: Home: ______________________________

Work: ______________________________

E-Mail: __________________________ Cell: ______________________________

Emergency Contact Information:

Name: __________________________________ Relationship: __________________

Phone: _________________________________ Cell: __________________________

Parent, Guardian, Foster Parent, or Other financially responsible party (Guarantor) if different from Patient: Name, Address, Telephone, Date of Birth, Relationship:

____

____

Do you have **MEDICARE**? YES NO / If yes, Medicare #______________________

DENTAL INSURANCE
PRIMARY PLAN
Insured Name: _________________________________ Date of Birth:__________
Insurance Company Name: ____
Insurance ID #: __________________________ Relationship to Patient: __________

SECONDARY PLAN
Insured Name: _________________________________ Date of Birth:__________
Insurance Company Name: ____
Insurance ID #: __________________________ Relationship to Patient: __________

Pharmacy Name, Telephone: ____

Race (you may elect not to answer this question) (check all that apply)
_____African-American/Black _____Hispanic/Latino _____Asian/Pacific Islander
_____Caucasian/White _____Native American _____Other: please specify_________
Do you need an interpreter? No Yes If yes, please specify language: ______________
How did you hear about us?____
Name of person completing this form if not self: ___________________________
Relationship to patient: ____

Stony Brook
School *of* Dental Medicine

Patient Phone, Text Message and Email Form

Patient Name: ______________________ Date: __________

Please let us know how you wish to be contacted.

- You may choose any of the following methods for an appointment reminder or other information to be sent to you.
- Please understand that you may choose any one or combination of the following methods which works best for you.
- You may elect not to utilize any of the following.
- You may change this choice at any time.

Please select any one or combination of methods:

________ Send voice reminders to my home telephone. These messages will be a reminder of my previously booked appointment date, time and department, or a notification that I need to make an appointment.

HOME PHONE #: ______________________

________ Send voice reminders to my mobile telephone. These messages will be a reminder of my previously booked appointment date, time and department, or a notification that I need to make an appointment.

MOBILE PHONE #: ______________________

________ Send text messages to my mobile telephone. These messages will be a reminder of my previously booked appointment date, time and department, or a notification that I need to make an appointment.

MOBILE PHONE #: ______________________

________ Send email reminders to email address. These messages will be a reminder of my previously booked appointment date, time and department, or a notification that I need to make an appointment.

EMAIL: ______________________

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Patient Name:		Date:	

Please answer the questions below. If you do not understand any of the questions or are unsure, please ask for help. This is a screening medical history and requires a comprehensive update prior to patient care.

What is your reason for seeking dental care? ____________________

Have you been seriously ill or hospitalized in the last 5 years? YES NO

If YES, please describe: ____________________

Have you had dental radiographs (X-rays) recently? YES NO

If YES, when? ____________________ Where? (List Dentist's Address) ____________________

DO YOU HAVE or HAVE YOU HAD ANY of the FOLLOWING? PLEASE CIRCLE YES OR NO.

ALLERGIES Which type? ______	YES	NO	ARTIFICIAL JOINTS (hip, knee, other)	YES	NO	KIDNEY DISEASE(S)	YES	NO
TAKING BLOOD THINNERS List: ______	YES	NO	HIV	YES	NO	CANCER Which type: ______	YES	NO
ENDOCARDITIS	YES	NO	HEPATITIS Which type? ______	YES	NO	THYROID DISEASE(S)	YES	NO
HEART ATTACK When? ______	YES	NO	TUBERCULOSIS	YES	NO	PSYCHIATRIC DISORDERS	YES	NO
ARTIFICIAL HEART VALVE	YES	NO	EPILEPSY OR SEIZURE DISORDER	YES	NO	JAW JOINT PROBLEM? (TMJ Problem)	YES	NO
STROKE	YES	NO	RESPIRATORY DISEASE(S)	YES	NO	ORGAN TRANSPLANT(S)	YES	NO
HIGH BLOOD PRESSURE	YES	NO	LIVER DISEASE(S)	YES	NO	OTHER CHRONIC DISEASES List: ______	YES	NO

For Women

ARE YOU PREGNANT? YES NO If YES, how many months? ______

Stony Brook
School *of* Dental Medicine

School of Dental Medicine
Dental Care Center

Name ______________________________ Account __________________________

Notification Policy

It is our policy not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone or pager. When returning calls and an answering machine picks up; we do not leave a message unless it is an appointment reminder. Information also will not be left with an unauthorized person who may answer the phone.

If you would like to have information released to someone other than yourself, please complete the following:

I authorize the staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

___ Yes ___ No Home Telephone ____________________________________

___ Yes ___ No Home Answering Machine ______________________________

___ Yes ___ No Fax Home ____

___ Yes ___ No Fax Work ____

___ Yes ___ No Work Phone/Voicemail _______________________________

___ Yes ___ No Cell Phone/Voicemail ________________________________

___ Yes ___ No E-mail ____

___ Yes ___ No Pager ____

Please list names of authorized people we may leave messages with (i.e. spouse, boyfriend, girlfriend, parent, grandparent, etc.):

Name ____________________________ Relationship __________________________ ___ Yes ___ No

Name ____________________________ Relationship __________________________ ___ Yes ___ No

Name ____________________________ Relationship __________________________ ___ Yes ___ No

Who may we discuss your financial situation with?

Name ____________________________ Relationship __________________________ ___ Yes ___ No

Name ____________________________ Relationship __________________________ ___ Yes ___ No

____ ________________________

SIGNATURE (Patient/Guardian) **DATE**

CHART # ________________

Program Selection Appointment Treatment Plan

Welcome to the Dental Care Center. Your appointment today is for Pre-diagnostic services which include a screening triage and head and neck examination. A Panorex X-ray may be taken as part of the examination process.

The goal of this visit will be to evaluate your specific dental needs and determine which program is best suited for you. No additional treatment will be performed at today's visit.

Please feel free to discuss your dental care concerns with our students, faculty or staff.

Charge for today's appointment: $46.00
I authorize the performance of the above dental treatment as approved by the faculty member(s) of the Dental Care Center.

1. Not all insurance plans cover the charge for this appointment. I understand and accept the charge of $46.00 for this Program Selection Appointment if not covered by my insurance. I understand and accept that this is a non-refundable, non-transferrable charge.
2. I acknowledge that I have received no guarantees or assurances about the outcome of the treatment or any of its component(s), benefits or results.
3. Limitations of Insurance Coverage: My insurance may not cover every procedure that is recommended. I understand that what may be quoted as my portion (Estimated Patient Responsibility) is only an estimate. I agree to be financially responsible for charges not covered by my insurance company.
4. MEDICAID beneficiaries only: Member Financial Responsibility Consent Form-to be completed
   It has been explained to the beneficiary what the service is and the cost, along with risks, benefits and alternatives. By the patient/guardian signature, the patient/guardian understands and accepts the financial responsibility for these services. I have been thoroughly informed that alternate treatment may be available, and the dental treatment agreed to in this treatment plan is not covered by my insurance plan. I further understand that if I agree to this treatment, I am responsible for all charges listed agreed to in this treatment plan.

Patient Name: ________________________________
Print Name

Patient Name: ________________________________ **Date:** ____________________
Signature of Patient

Stony Brook
School of Dental Medicine

DIRECTIONS TO THE SCHOOL OF DENTAL MEDICINE

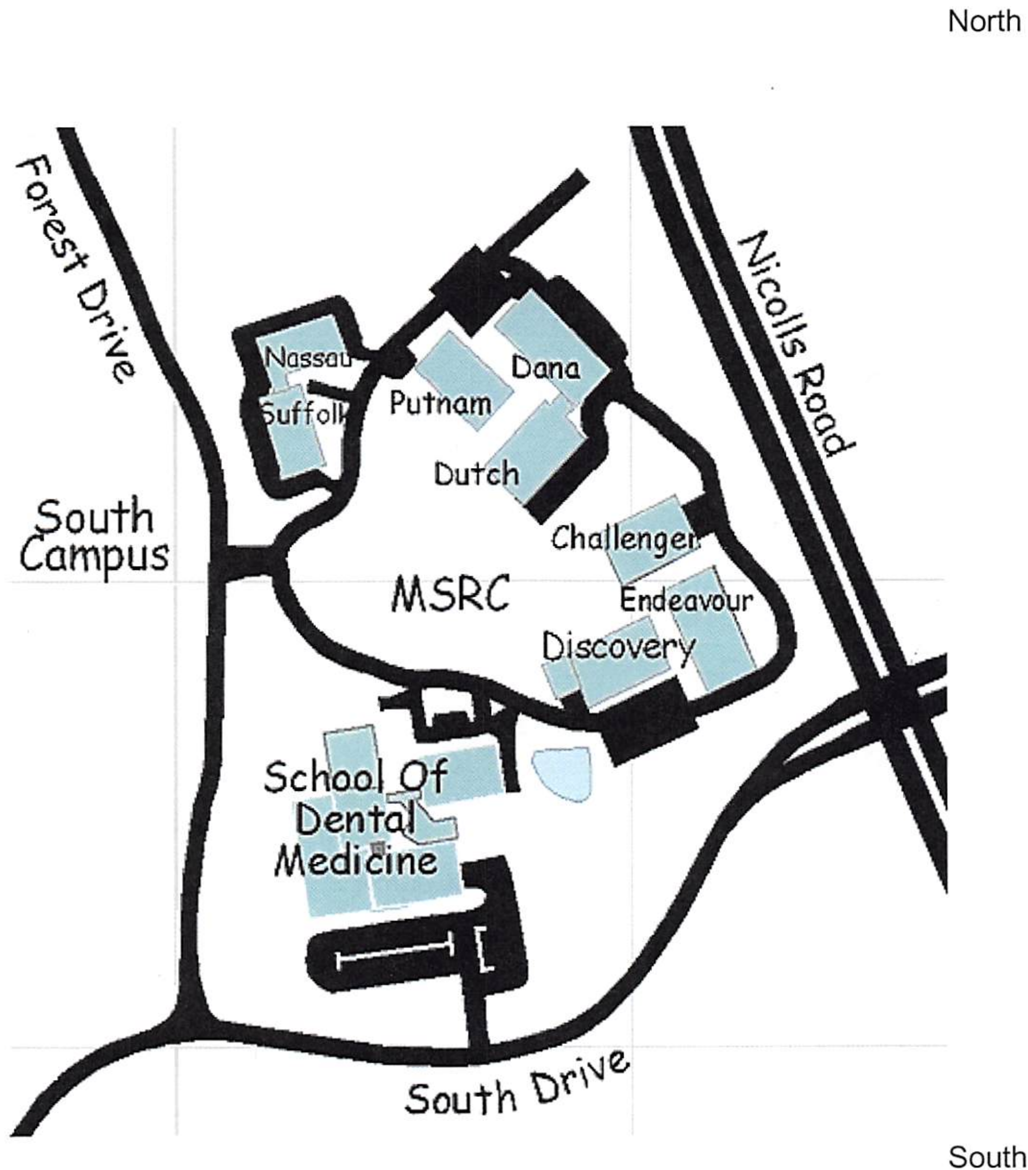
From the West:

Take Long Island Expressway (LIE I-495) eastbound to exit 62 North, Nicolls Road (Route 97). Travel approximately 8 miles (crossing Route 347). Follow signs to the School of Dental Medicine, Dental Care Center, then follow directions below, Stony Brook South Entrance, West Campus."

From the East:

Take Long Island Expressway (LIE I-495) westbound to exit 62 North, Nicolls Road (Route 97). Travel approximately 8 miles (crossing Route 347). Follow signs to the Hospital/Dental Clinics, and then follow directions below, From the Stony Brook South Entrance, West Campus

North



South

Medicaid/Medicaid HMO

Plan	Company
NYS Medicaid	NYS Medicaid
Affinity Health - Medicaid	Dentaquest
Affinity Health - Child & Family Health Plus	Dentaquest
Catholic Health Plan (Fidelis Care) Medicaid	Dentaquest
Catholic Health Plan (Fidelis Care) Child & Family Health Plus	Dentaquest
Fidelis Managed Long Term Care Medicaid	Dentaquest
HealthFirst Medicaid	Dentaquest
Healthfirst Family Health Plus	Dentaquest
Healthfirst Child Health Plus	Dentaquest
United Healthcare Community Plan Medicaid	United Healthcare
United Healthcare Community Plan Family or Child Health Plus	United Healthcare
Emblem Health- HIP Medicaid	Dentaquest
Emblem Health- HIP Child Health Plus	Dentaquest
Shinnecock Indian Health Services	Shinnecock Indians
Unkechaug Indian Health Services	Unkechaug Indians

HEALTHPLEX INSURANCES

Plan	Group Number
Aetna Medicaid	GG-509
Health Plus Empire BlueCross BlueShield	GG-466 NYC (child) GG-466 NYA (adult)
Health Plus Empire BlueCross BlueShield.	GG-466 CHP1 or FHP1

Elderserve	GG-502 LI
Quality Health Plan	GG-494
Wellcare Medicare	GG-495
Wellcare Medicare	GG-495-500
Wellcare Medicare	GG-495-750
Wellcare Medicare	GG-495-1000

PRIVATE INSURANCES

Plan	Ins Code
CSEA	CSEA
CIGNA PPO	CIGNA
Delta Dental*	DEL-**
Emblem Health Preferred PPO ***	EMBLEM

*** WE DO NOT PARTICIPATE WITH DELTA CARE USA**

** **Delta has many plans please check the card for the correct plan**

*** **This includes GHI and HIP (No HMO)**