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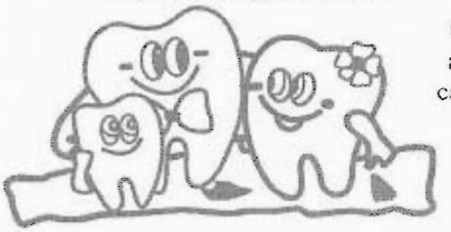

Lyudmila Onyski DDS
–"Let Us Take Care Of You and Your Smile"

Welcome to our office! We look forward to providing you with the best dental treatment possible, and we thank you for giving us the opportunity to meet you and your family. Please complete the following paperwork in its entirety so we can give you the best care possible. If you need help or require assistance, please ask-we are more than happy to help!

PATIENT INFORMATION (CONFIDENTIAL)

Name_____

Birth date:_____SS:_____

Address:_____City:_____State_____Zip_____

Primary Language_____Translation Needed Y N

E-Mail_____ Cell Phone_____

Home Phone:_____Work Phone_____

Name and Number of Emergency Contact_____

Single Married Divorced Widowed Separated

Employer:_____Occupation:_____

Previous/Present Dentist_____ Last Visit Date:_____

How did you hear about us?_____

Sign:_____Date:_____

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. Do you use tobacco?	☐	☐
7. Do you use controlled substances?	☐	☐

	Yes	No
9. Are you wearing contact lenses?	☐	☐
10. 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) _____		
11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
12. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

8. Do you have or have you had any of the following?

	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 _____	☐	☐
Acid Reflux	☐	☐	Osteoporosis	☐	☐			

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 dependents.

X _____

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

Doctor's Comments _____

Signature _____ Date _____

Wayside Family Dental

Consent For Treatment

1. I hereby authorize Dr. Onyski or designated staff to take x-ray, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (Name of Patient)_____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedative, and other medication as necessary, I fully understand that using anesthetic agents embodies certain risks, I understand that I can ask for complete recital of any possible compilations.

4. I give consent to Dr. Onyski or designated staff's use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and health care operations, I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a fully outlining the protection of my personal health information is available.

Patient's Signature_____Date_____

Parent/Responsible Party's Signature_____

Relationship to Patient_____

Patient Authorization For Disclosure Of protected Health Information (PHI)

I wish to be contacted in the following manner (check all that apply)

_____**Home telephone**_____

_____ **O.K. to leave a message with information**
_____ **Leave message with a call-back number only**

_____**Work Telephone**_____

_____ **OK to leave a message with information**
_____ **Leave a message with a call back-number**

_____**Written communication**

_____ **OK to mail to my home address**

_____**E-Mail Communication**

_____ **OK to e-mail information to the following e-mail address**

_____

_____**List 2 individuals authorize for communication**

1. _____

2._____

Patient Signature_____ **Date of Birth**_____

Print Name_____ **Date**_____

Wayside Family Dental

Our Financial Alliance Philosophy

It is important to us that the quality of our business services matches the quality of our dentistry. We want the handling of your account, from the start through final payments to be perceived as an extension of the dental care we provide you and your family. We believe that no dental problem should ever become a financial burden.

Patient's Role

As with any partnership, both parties have a role to play. Our role is to provide you with quality service. In turn, your role is to pay for your treatment at time of service.

In developing a financial arrangement it is important to remember your dental future. Our experience has shown that when an account lingers, patients are likely to defer their appointments. Unfortunately, this can also lead to a patient's not showing up to appointments, or canceling without 24 hours notice. It is discouraging to add new charges to an account when trying to pay off old debt, however, it is our policy to charge $50.00 per half hour scheduled for any broken/ cancelled appointments, without at least 24 hour notice.

WE ACCEPT CASH, CHECKS OR VISA MASTERCARE AND CARE CREDIT

If using dental insurance, I agree to pay the full fee of the treatment rendered. Any portion not paid by my insurance, for any reason, is solely my responsibility. I recognize that Wayside Family Dental is not a party to the contract I hold with my insurance, and that any disputes, unpaid balances. Etc., are to be between myself and my insurance company only. I understand that if my account reaches collection status (90 days) and I make no effort to pay off my account, my account will be assigned to a collection attorney. If Wayside Family Dental must take additional steps to collect on my account, I will pay ALL cost of collection, including court cost and attorney's fees incurred by them.

I have read the Financial Alliance. I understand, accept, and agree to this Financial Alliance.

Sign:_____ Date_____

Witness for Wayside Family Dental_____ Date_____