University at Buffalo
School of Dental Medicine

Thank you for your interest in the UB School of Dental Medicine (UB Dental).

Please complete the following information and return to UB Dental Patient Admissions, 103 Squire Hall, Buffalo, New York 14214 and a staff member from Patient Admissions will contact you within 5 days of receipt of your paperwork to schedule a New Patient Screening appointment. There is a fee for the screening visit as well as fees for radiographs (x-rays).

Visit our website @ http://dental.buffalo.edu/ and click on "Patient" to view the "Patient Orientation Video" for helpful information regarding your upcoming experience at the University at Buffalo School of Dental Medicine.

Enclosed please find:

1) Parking permit with instructions (allows for free parking in clinic patient parking areas only)
2) Clinic Patient Parking brochure (a map of patient parking areas on campus)
3) Medical History Questionnaire
4) Oral and Dental History Questionnaire
5) Patient Application (Demographic Form)
6) Insurance Information Letter
7) Prospective Patient Information
8) Acknowledgement of Patient Rights and Responsibilities

Before you are contacted you MUST return the following completed forms (front and back sides if applicable) to UB Dental Patient Admissions, 103 Squire Hall, Buffalo, New York 14214**:**

1) Patient Application
2) Oral and Dental History Questionnaire
3) Medical History Questionnaire
4) Acknowledgement of Patient Rights and Responsibilities
5) Copies of recent radiographs (x-rays) from your previous dental care provider (if applicable). If you have current x-rays of good quality, it MAY exempt you from the fee for radiographs. However, your x-rays MUST be less than one year old, of good quality (paper copies of digital x-rays are NOT acceptable), and must be received with your paperwork **prior** to your New Patient Screening visit.

On the day of your scheduled appointment:

1) Park your vehicle in one of the designated patient parking areas (see brochure)
2) Place the enclosed parking permit on the dashboard of your vehicle.
3) **Check in with the receptionist at the Patient Admissions window, room 103.**
4) **There is a $54 fee for the screening visit as well as radiographs (x-rays) taken during that visit.** If you are paying by check or Money Order, please make payable to "UB School of Dental Medicine". Cash, MasterCard, Visa and Discover are also accepted. **Patients with Medicaid insurance MUST present his/her card upon check in for eligibility verification.**
5) Photo I.D. will be required at the screening appointment, and may also be requested at any other time. Please remember to bring this document with you to your scheduled appointment. This is in accordance with the Federal Trade Commission Red Flags Rule (16 CFR 681.2).
6) Wheelchairs are available (if needed) from the first floor receptionist.

Questions regarding the application process can be directed to Patient Admissions at (716) 829-2732.

Business Operations

103 Squire Hall, Buffalo, NY 14214
716.829.2732
dental.buffalo.edu

UB School of Dental Medicine

Patient Application (Please Print)

Mr. Mrs. Miss Ms. Dr. Name_____
Last First Middle Initial

Date of Birth: _ _/_ _/_ _ M F Social Security Number _ _ _/_ _/_ _ _ _

Email address: _____

Race / Ethnicity: (circle one) Caucasian African American Asian Hispanic Other
Any special needs we should know about? Blind Deaf Wheelchair Other _____
Preferred language? _____

Have you ever been treated at the UB School of Dental Medicine in the past? Y N

Are you a UB student? Y N If yes, SUNY ID Number_____

Do you have a healthcare proxy? Y N
If so, who is your appointed agent? _____
Phone number of appointed agent: _____

Local Address: Permanent Address if different than local:

Street_____ Street_____

Apt. _____ Apt_____

City _____ City_____

State / Province_____ State / Province_____

Country_____ Country _____

ZIP / Postal Code _____-_____ ZIP / Postal Code _____- _____

Daytime Phone _____ Evening Phone_____

Cellular Phone _____Preferred Contact Number (circle): Day Eve Cell

If you are covered by Medicaid (including Medicaid Managed Care Plans administered by Healthplex or Dentaquest), please complete the following:

New York State Department of Social Services BENEFIT Identification Card

ID Number /___/___/___/___/___/___/___/___/___/

Name: _____ Sex : M F

Birth Date: _____

Signature of Applicant:_____ Date:_____

Pt App Rev. 6/29/16 rlc

University at Buffalo
The State University of New York

School of Dental Medicine
Business Operations

PROSPECTIVE PATIENT INFORMATION

Thank you for your interest in becoming a patient at the University at Buffalo School of Dental Medicine (UB Dental). As a patient, you will make an important contribution to the education of our student dentists. Prior to acceptance, we require prospective patients to proceed through a "New Patient Screening Appointment."

Application and screening do not guarantee acceptance. Many factors influence your acceptance into our educational program including, but not limited to: the current condition of your oral health and your availability. Once we receive your completed application, a staff member from Patient Admissions will contact you within 5 days to schedule an appointment.

WHY MUST I COMPLETE THE APPLICATION BEFORE AN APPOINTMENT WILL BE SCHEDULED?

Due to the economic value and the high quality of dental services offered at UB Dental, there is often a waiting list to become screened and accepted as a patient. Obtaining all required documentation prior to the screening will help streamline your visit.

HOW MUCH IS THE SCREENING, AND WHY IS ONE REQUIRED?

A non-refundable fee of $54.00 has been set to cover the cost of establishing a patient record, processing the information, the initial evaluation and a panoramic radiograph (x-ray), if needed. If current x-rays of good quality have been received prior to your New Patient Screening Appointment, you may not require the panoramic x-ray. Please make check or money order payable to "UB School of Dental Medicine." Individuals with Medicaid insurance are **NOT** required to pay the fee; however, you must provide us with enough information to determine your Medicaid eligibility. Fees are subject to change at any time.

FAILURE TO BRING MEDICAID CARD OR PAY SCREENING FEE WILL RESULT IN HAVING TO RESCHEDULE YOUR APPOINTMENT.

WHAT WILL HAPPEN AT THE SCREENING APPOINTMENT?

Your screening appointment will consist of the following: 1) A student dentist and faculty member will review your medical and dental health history forms that are to be completed by you prior to your appointment. 2) A preliminary assessment of your current dental condition will be completed. 3) **Appropriate radiographic (x-ray) studies may be ordered based on your specific diagnostic needs**. 4) **Photo I.D. will be required** at the screening appointment and may also be requested at any other time. Please remember to bring this document with you to your scheduled appointment. This is in accordance with the Federal Trade Commission Red Flags Rule (16 CFR 681.2). 5) You will receive a complimentary toothbrush and floss.

Patients who do not qualify to participate in our clinical educational program will be notified. We regret that all patients screened cannot be accepted for dental care. Your treatment may be too complex for student dentists and may be best managed by a private dentist or your availability may not match that of our clinic schedule.

CONTINUED ON BACK

Business Office, Squire Hall, Rm 108 (716) 829-3226
Patient Admissions, Squire Hall, Rm 103 (716) 829-2732
Patient Records, Squire Hall, Rm 103 (716) 829-2526
3435 Main Street, Building 32, Squire Hall, Buffalo, NY 14214-3008

DENTAL TREATMENT FEES: HOW MUCH WILL IT COST?

The fees charged are substantially less than the cost of care from a private dentist. The fees for treatment being provided by students are 1/3 to 2/3s lower than in private practice. For patients with advanced dental needs, it may become necessary to refer all or some of your treatment to one of the post-graduate or specialized clinics. Fees for treatment in the advanced clinics are higher than those offered in the student (pre-doctoral) dental clinics, because the providers are graduate dentists working either toward a specialized degree or gaining additional experience in a general dentistry setting. You will be informed if all or part of your dental care requires referral to one of these clinics. Your estimated fees will be presented to you along with a treatment plan before any substantial treatment has begun. Because the SDM is a New York State educational institution, payment plans cannot be offered, and **payment is required at time of service.**

If you are a Medicaid recipient, please be aware that Medicaid does not cover all dental procedures. Once accepted as a registered patient, you should discuss all planned treatment with your assigned student so that Medicaid coverage can be determined before treatment begins.

HOW LONG ARE APPOINTMENTS?

Since the SDM is a teaching facility, the length of your appointments and overall treatment will likely take longer than it would from a private dentist. High standards are required of our student dentists, and our clinical faculty continually evaluate the student's abilities and skills. Treatment at the SDM typically progresses more slowly and requires more frequent visits. **Therefore, you should expect to spend approximately 3 hours per appointment.** This attention to detail requires more of your time, but assures you of quality dental care.

If your schedule is such that it is difficult for you to come frequently and stay for the rather lengthy appointments often required, then you should consider seeking care from another dental provider.

MY CHILDREN NEED DENTAL CARE. WHOM MAY I CONTACT?

The UB School of Dental Medicine has a Pediatric Dental Department which specializes in dental care for toddlers, children and adolescents (Ages 0-17). This department handles their own screening appointments, and you may contact them directly for additional information at (716) 829-2723.

MY CHILDREN MAY NEED BRACES. WHOM MAY I CONTACT?

The School of Dental Medicine has an Orthodontic Department which specializes in correcting problems associated with spacing and crowding of teeth. This department offers screening at various times of the year. For acceptance into their clinics, you may contact them directly for additional information at (716) 829-2845.

CLINIC HOURS

Clinic hours are 9:00 AM to 12:00 PM and 1:00 PM to 4:00 PM Monday through Friday. Clinics are closed weekends and some holidays that are recognized by the University.

Questions regarding the application process

may be directed to Patient Admissions at (716) 829-2732.

UNIVERSITY AT BUFFALO
The State University of New York
U.B. DENTAL
Business Operations

Dear Patient,

Thank you for requesting information about becoming a patient of U.B. DENTAL.

Regarding Payment for Dental Services & Dental Insurance

Payment is due at the time of service. U.B. DENTAL accepts cash, credit cards, and personal checks. U.B. DENTAL participates in the Healthplex (for Independent Health, BlueCross BlueShield, and Univera) and Dentaquest (for Fidelis) Medicaid and Family Health/Child Health Plus programs.

For Patients with Private Dental Insurance

Patients with insurance other than Medicaid and Family/Child Health Plus mentioned above must pay at the time of service. As a courtesy to such patients, U.B. DENTAL will provide a summary of procedures paid in full, which can then be submitted to the insurance company for reimbursement. If you would like such a form, please request it from the cashier.

Patients with private insurance are strongly encouraged to contact their insurance company for coverage and eligibility information *prior* to beginning treatment because some insurance companies will not reimburse for treatment rendered in an educational setting.

Please Call Us with Any Questions

Please feel free to contact us at 829-3226 should you have any questions about making payment for dental services.

Thank you.

Business Office, Squire Hall, Room 108, (716) 829-3226
Patient Admissions, Squire Hall, Room 103, (716) 829-2732
Patient Records, Squire Hall, Room 103, (716) 829-2526
3435 Main Street, Building 32, Buffalo, NY 14214-3008

Ins. Letter Revised 10.18.16

SUNY at Buffalo / School of Dental Medicine

File No. | | | | | | |

ORAL AND DENTAL HISTORY QUESTIONNAIRE

Patient Name: _____

In general, how would you characterize your past dental care? ❒ Routine ❒ Episodic ❒ Emergency

When was the last visit to a dentist?: _____

What was it for?: ❒ Checkup ❒ Filling ❒ Toothache

Have you ever had a bad experience during dental treatment?: ❒ Yes ❒ No

What was it for?: ❒ Fainting ❒ Bleeding ❒ Reaction to local anesthetic

Have you ever had a complete set of dental x-rays of any type?: ❒ Yes ❒ No

When were your last dental x-rays of any type?: ❒ One year ago ❒ Two years ago ❒ Three years ago

How often do you brush your teeth?: _____ What kind of brush do you use?: _____

Has anyone ever shown you how to clean your teeth?: ❒ Yes ❒ No

If yes who?: _____

How often do you floss?: _____

Does floss catch, fray or break in any area of your mouth?: ❒ Yes ❒ No

Do you brush your tongue?: ❒ Yes ❒ No

Do you (or the patient if a child) have any habits that involve your mouth?: ❒ Yes ❒ No

If yes check all that apply?: ❒ thumb sucking ❒ going to bed with bottle

❒ grinding ❒ clenching ❒ biting nails ❒ holding pins

Do you think you have bad breath?: ❒ Yes ❒ No

Do you use a mouth rinse?: ❒ Yes ❒ No

Do your gums bleed?: ❒ Yes ❒ No

Do you have any trouble talking?: ❒ Yes ❒ No

Is your mouth dry?: ❒ Yes ❒ No

Have you lost time from work or school because of dental problems? ❒ Yes ❒ No

Are you satisfied with the oral care you have received?: ❒ Yes ❒ No

Are you aware of any swelling, soreness, rough areas, ulcers, erosions or color changes in your mouth?: ❒ Yes ❒ No

Have you ever had any of the following types of dental treatment? (check all that apply):

❒ braces ❒ implants ❒ jaw surgery not involving teeth ❒ gum surgery ❒ root canal

Have you had radiation to your head and neck?: ❒ Yes ❒ No

Do you eat candy and snack food?: ❒ Yes ❒ No

Do you use tobacco?: ❒ Yes ❒ No

Do you drink alcohol?: ❒ Yes ❒ No

What type of dental work do you think you need? _____

_____

_____

TOOTH RELATED HISTORY:

Do you like the way your teeth look?:	❒ Yes	❒ No
Do any of your teeth feel loose?:	❒ Yes	❒ No
Are your teeth sensitive to heat, cold or sweets?:	❒ Yes	❒ No
Do you have pain, soreness, or tenderness in any head or neck muscles?:	❒ Yes	❒ No
Do you grind, clench or grit your teeth?:	❒ Yes	❒ No
Are there any new spaces between any teeth?:	❒ Yes	❒ No

PROSTHETIC (DENTURE / PARTIAL DENTURE) HISTORY:

Do you have dentures?: ❒ Yes ❒ No

If yes, ❒ Upper ❒ Lower

Do you have partial dentures?: ❒ Yes ❒ No

If yes, ❒ Upper ❒ Lower

Why were your teeth removed?: _____

Do you have any problems with your jaw bone?: ❒ Yes ❒ No

Do you have any problems wearing your dentures / partials?: ❒ Yes ❒ No

How many dentures / partials do you have?: _____

How do you clean your dentures / partials?: _____

Do you wear you denture / partials all of the time?: ❒ Yes ❒ No

TMD HISTORY:

Do you have difficulty or pain, or both, when opening your mouth, as for instance, when yawning?	❒ Yes	❒ No
Does you jaw get "stuck", "locked", or "go out"?	❒ Yes	❒ No
Do you have difficulty or pain, or both, when chewing, talking or using your jaws?:	❒ Yes	❒ No
Are you aware of noises in the jaw joints?:	❒ Yes	❒ No
Do you have pain in or about the ears, temples, or cheeks?:	❒ Yes	❒ No
Does your bite feel uncomfortable or unusual?:	❒ Yes	❒ No
Do you have frequent headaches?:	❒ Yes	❒ No
Have you had a recent injury to your head, neck or jaw?:	❒ Yes	❒ No
Have you previously been treated for a jaw joint problem?:	❒ Yes	❒ No

If yes when? _____

Student Signature: _____ Date: _____

Faculty Signature: _____ Date: _____

SUNY at Buffalo / School of Dental Medicine

File No. ☐☐☐☐☐☐

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____

Weight _____ Height _____ ❒ Married ❒ Single Occupation _____ How Long _____

In the following questions, check yes or no, whichever applies.
Your answers are for our records and will be considered confidential.

		Yes	No
1	ARE YOU IN GOOD HEALTH	❒	❒
	a Has there been any change in your general health within the past year	❒	❒
2	MY LAST PHYSICAL EXAMINATION WAS ON		
3	ARE YOU NOW UNDER THE CARE OF A PHYSICIAN		
	a If so, what is the condition being treated		
4	THE NAME AND ADDRESS OF MY PHYSICIAN IS		
5	HAVE YOU HAD SERIOUS ILLNESS OR OPERATION	❒	❒
6	HAVE YOU BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS WITHIN THE PAST FIVE (5) YEARS		
	a If so, what was the problem		
7	DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS		
	a Rheumatic fever or rheumatic heart disease	❒	❒
	b Congenital heart lesions	❒	❒
	c Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)	❒	❒
	d Do you have pain in you chest upon exertion	❒	❒
	e Are you ever short of breath after mild exercise	❒	❒
	f Do your ankles swell	❒	❒
	g Do you get short of breath when you lie down, or do you require extra pillows when you sleep	❒	❒
	h Allergy	❒	❒
	i Asthma or hay fever	❒	❒
	j Hives or a skin rash	❒	❒
	k Fainting spells or seizures	❒	❒
	l Diabetes	❒	❒
	m Do you have to urinate (pass water) more than six (6) times a day	❒	❒
	n Are you thirsty much of the time	❒	❒
	o Does your mouth frequently become dry	❒	❒
	p Hepatitis, jaundice or liver disease	❒	❒
	q Arthritis	❒	❒
	r Inflammatory rheumatism (painful swollen joints)	❒	❒
	s Stomach ulcers	❒	❒
	t Kidney trouble	❒	❒
	u Do you have a persistent cough or cough up blood	❒	❒
	v Tuberculosis	❒	❒
	w Low blood pressure	❒	❒
	x Venereal disease	❒	❒
	y Other		
8	HAVE YOU HAD ABNORMAL BLEEDING ASSOCIATED WITH PREVIOUS EXTRACTIONS, SURGERY OR TRAUMA	❒	❒
	a Do you bruise easily	❒	❒
	b Have you ever required a blood transfusion	❒	❒
	If so, explain the circumstances		

		Yes	No
9	DO YOU HAVE ANY BLOOD DISORDER SUCH AS ANEMIA	❒	❒
10	HAVE YOU HAD SURGERY OR X-RAY TREATMENT FOR A TUMOR, GROWTH, OR OTHER CONDITION OF YOUR HEAD AND NECK	❒	❒
11	ARE YOU TAKING ANY DRUGS OR MEDICINE	❒	❒
	a If so, what:		
12	ARE YOU TAKING ANY OF THE FOLLOWING:		
	a Antibiotics or sulfa drugs	❒	❒
	b Anticoagulants (blood thinners)	❒	❒
	c Medicine for high blood pressure	❒	❒
	d Cortisone (steroids)	❒	❒
	e Tranquilizers	❒	❒
	f Insulin, tolbutamide (Orinase) or similar drug	❒	❒
	g Aspirin	❒	❒
	h Digitalis or drugs for heart trouble	❒	❒
	i Nitroglycerin	❒	❒
	j Other:		
13	ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO:		
	a Local anesthetics	❒	❒
	b Penicillin or other antibiotics	❒	❒
	c Sulfa drugs	❒	❒
	d Barbituates, sedatives or sleeping pills	❒	❒
	e Aspirin	❒	❒
	f Iodine	❒	❒
	g Other:		
14	HAVE YOU HAD ANY SERIOUS TROUBLE ASSOCIATED WITH ANY PREVIOUS DENTAL TREATMENT	❒	❒
	a If so, explain		
15	DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT	❒	❒
16	ARE YOU EMPLOYED IN ANY SITUATION WHICH EXPOSES YOU REGULARLY TO X-RAYS OR OTHER IONIZING RADIATION	❒	❒
17	DO YOU WEAR CONTACT LENSES	❒	❒
	WOMEN:		
18	ARE YOU PREGNANT	❒	❒
19	DO YOU HAVE ANY PROBLEMS ASSOCIATED WITH YOUR MENSTRUAL PERIOD	❒	❒

BLOOD PRESSURE:

date	sitting	standing	right arm	left arm

RECORD HISTORY OF SMOKING AND ALCOHOLIC CONSUMPTION

REMARKS

I agree to notify in writing the Director of Patient Evaluation and Management or the Associated Dean for Clinical Affairs if there is a change in my medical status as reported above.

Signature of Patient Date

Signature of Dentist Date

University at Buffalo
The State University of New York
School of Dental Medicine
Business Operations

Acknowledgement of Patient Rights and Responsibilities

As a patient of the University at Buffalo School of Dental Medicine (UB Dental), I understand I make an important contribution to the education of my student dentist. Observance of Patient Rights and Responsibilities will lead to more effective patient care and greater satisfaction for the patient and all those who function at UB Dental.

A complete list of Patient Rights and Responsibilities is included in the Patient Information Booklet, on-line at: http://dental.buffalo.edu/ and posted in several locations within the building.

Due to the economical value and the quality of dental services offered at UB Dental, there is often a wait list to become screened and accepted as a patient. Oftentimes, patients are unaware of their commitment to their student dentist, and are discharged as a result. As a patient I understand I must:

1. **Keep all appointments** – missing an appointment or canceling with less than 24-hour notice more than **2** times is grounds for discharge.

2. **Be available** - 3-4 times per month for a 3-hour clinic session – *includes the **winter** months.*

3. **Respond to my student dentist** – have a working phone number and return voice mail messages within *48 hours*

4. **Pay my bill in full at the time services are rendered**- grounds for discharge if over 60 days past-due

5. **Be on-time for appointments** –more than 15 minutes late is considered a missed appointment

6. **Follow the treatment plan recommended** – UB Dental does not operate like a private office – students are required to address all disease. Patients must consent to all examination procedures, tests, x-rays, premedication, local anesthesia and dental treatment ordered as indicated by sound and prudent dental practices. Patients cannot seek treatment with an outside provider while in active treatment.

7. **Be respectful of all SDM personnel** – *No Tolerance policy* - any inappropriate comments of a cultural, ethnic, or sexual nature are grounds for immediate dismissal.

8. **Provide proper childcare** – children who are not being treated are not allowed in clinics and are not to be left unattended.

I, _____ , fully understand I am making a commitment to my student dentist, which will take time, patience and mutual respect. I agree to all of the above requirements.

Patient _____ Date_____