Hackensack Meridian
Mountainside Medical Center

Mountainside Dental Department

Dear Patient:

Thank you for your interest in becoming a patient of our dental residency program at Mountainside Dental Department. We are a teaching facility that participates in the education of resident physicians. A resident physician is a graduate of dental school who is now training in their chosen specialty. They provide high quality dental health treatment under the supervision of certified teaching faculty. Our residency program observes the same standards of care and quality as a non-residency program dental office.

Here are the steps on how to become a patient of Mountainside Dental Department:

1. Complete the attached paperwork. Please read carefully as this paperwork contains important information, instructions and health questions that should not be overlooked.
2. Include a copy of current insurance card.
3. Include a copy of current valid photo ID (NJ driver's license, passport or green card) if minor, copy of parent's valid photo ID.
   Mail to Hackensack Meridian Mountainside Medical Center, Division of Dentistry, 1 Bay Avenue Montclair, NJ 07042.

Application is not complete if:

1. All included forms have not been properly completed and signed.
2. Requested copies of photo ID and insurance card are not attached.
3. The paperwork is received after due date.

After submitting your properly completed application, we will contact you for an appointment. However, if you have not heard from us in two weeks from submitting the documentation please call us at 973-429-6887.

If a message is left by the *Mountainside Dental Department staff member*, the patient/guardian will have up to 10 days to make an appointment.

Make sure you mark your calendar with your appointment's Date and Time. If the appointment is missed, it will not be re-scheduled and you will have to wait until the next new patient opportunity.

Thank you

Hackensack Meridian Mountainside Medical Center
Division of Dentistry

Hackensack Meridian
Mountainside Medical Center

Mountainside Dental Department

PLEASE PRINT

PATIENT NAME: (LAST, FIRST) _____

PATIENT GENDER: Male _____ Female____ Patient S.S. # _____-____-_____ DATE OF BIRTH: _____

CELL PHONE: (____) _____- _____ HOME PHONE: (____) _____- _____ WORK PHONE: (____) _____- _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMAIL: _____

RACE: _____ LANGUAGE: _____

Previous Dentist:_____ Referred by Dentist: _____

IF MINOR:

GUARDIAN/PARENT NAME: (LAST, FIRST) _____

DATE OF BIRTH: _____ GENDER: MALE____ FEMALE ____

CELL PHONE: (____) _____- _____ HOME PHONE: (____) _____- _____ WORK PHONE: (____) _____- _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMERGENCY CONTACT:

CLOSEST RELATIVE NAME: _____ PHONE NUMBER: (____) _____- _____

RELATIONSHIP: _____

PRIVATE DENTAL INSURANCE INFORMATION (please provide an insurance card):

INSURANCE NAME: _____ PHONE NUMBER: (____) _____- _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____ PAYOR ID: _____

GROUP NUMBER: _____ GROUP NAME: _____

SUBSCRIBER NAME: _____ DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____-_____-_____ EMPLOYER NAME: _____

STATE INSURANCE INFORMATION (please provide an insurance card):

MEDICAID CCN#: _____ MEDICAID ID#: _____

AETNA BETTER HEALTH ID#:_____AMERIGROUP/ WELLPOINT ID#: _____

HORIZON NJ HEALTH ID#: _____ UNITED HEALTH CARE ID#: _____

WELLCARE/FIDELIS ID#:_____

Hackensack Meridian
Mountainside Medical Center

Mountainside Dental Department
Outpatient Assessment

ADVANCE DIRECTIVE

Advance Directive, sometimes called a Living Will, is a written document signed by you, in which you decide the kind of care you would want, if for any reason you are unable to make Healthcare decisions for yourself.

Please note: Your Advance Directive should be shared with your Primary Physician and brought to the Hospital upon Inpatient admission.
Advance Directives will be honored on an inpatient basis.

	Yes	No
Do you have an Advance Directive?		
If No, Would you like information?		

Patient name

_____

Date of Birth

_____

Boxes Below for Hospital Use only

Advance Directive Information given:
Yes NA Refused

FALL RISK ASSESSMENT

	Yes	No
Do you have a history of falls?		
Do you walk with an assistive device as a walker or cane?		
Do you take any of these medications:		
Psychiatric?		
Tranquilizers?		
Sleeping pills?		
Pain pills prescribed by your doctor?		
Do you have any of these health conditions:		
Parkinson's Disease?		
Stroke?		
Confusion or forgetfulness?		
Alzheimer's Disease?		
Seizure disorder?		

Fall Prevention Guide given:
Yes NA Refused

SOCIAL ASSESSMENT

Domestic Violence/Neglect is a pattern of **abuse/neglect** by one individual over another.
Abuse can be verbal, emotional, physical, sexual or economic.

	Yes	No
Do you feel safe in your home environment?		
Do you feel safe at work or school?		

Social Service Referral information given:
Yes NA Refused

Patient/Guardian/Family Signature_____

Reviewed assessment with patient and/or family, appropriate information or referrals made as above.

Dentist Signature _____ **Date** _____

Healthcare Professional_____ Date_____

Hackensack Meridian
Mountainside Medical Center

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: ____ /____ /_____

Sex F/M Weight: _____ Height: _____

Name and phone number of your Primary Care Physician and Specialist:

_____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be confidential. Please note that during your initial visit, you will be asked some questions to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health? _____ Yes No
2. Has there been any changes in your health within the past year_____ Yes No
3. When was your last physical examination_____
4. Are you now under the care of a physician _____ Yes No
   If yes, what is the condition being treated? _____
5. Have you had any serious illness, operations, or been hospitalized in the past 10 years? _____ Yes No
   If yes, what was the illness or problem? _____
6. Are you taking any medication(s) including non-prescription medicine? _____ Yes No
   Please list: _____
   _____
   _____
7. Do you have or have you had any of the following disease conditions?
   a. Damaged/artificial heart valves, heart murmur, rheumatic heart disease, or pacemaker _____ Yes No
   b. Cardiovascular disease (heart attack, angina, abnormal heart rate, high blood pressure, arteriosclerosis, stroke)____ Yes No
   c. Diabetes _____Yes No
   d. Hepatitis, jaundice or liver disease _____Yes No
   e. Abnormal bleeding, anemia, leukemia, lymphoma – What type? _____ Yes No
   e. AIDS or HIV infection _____Yes No
   f. Respiratory problems – persistent cough, asthma, emphysema, bronchitis, etc. _____ Yes No
   g. Arthritis or painful swollen joints _____ Yes No
   h. Tumor, growth or cancer_____ Yes No
   i. Epilepsy (seizures) or other neurological disease _____ Yes No
   j. Psychiatric problems (depression, anxiety, bipolar disorder) _____ Yes No
   k. Any disability_____ Yes No
   l. ADD/ADHD, Autism _____ Yes No
8. Do you have osteoporosis? _____ Yes No
9. Do you take or have you ever taken any Bisphosphonate medication? _____ Yes No
   If yes, which ones? _____
10. Are you allergic or have you had a reaction to:
    ☐ Local anesthetics ☐ Penicillin or other antibiotics ☐ Aspirin ☐ Latex
    ☐ Codeine or other narcotics ☐ Other _____ ☐ None

Hackensack Meridian
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11. Do you smoke, vape or use any tobacco products? _____ Yes No
    If yes, how much? _____
12. Do you use any recreational drugs, including CBD? _____ Yes No
    If yes, which one? _____
13. How often and how much alcohol do you consume? _____Never _____ Daily _____ Weekly _____ Monthly

WOMEN

1. Are you pregnant? _____ Yes No
2. Are you nursing? _____ Yes No
3. Are you taking birth control pills? _____ Yes No

Is there anything else that you think I should know about you? _____ Yes No
If yes, explain:
_____
_____

Chief Dental Complaint:
_____

I certify that I have read and understand the above. To the best of my knowledge, I have answered every question completely and truthfully. I will not hold my dentist, or any other member of his/her staff, responsible for any omissions that I may have made in the completion of this form.

Date: _____ Signature of Patient/Guardian: _____

If not patient signature, what is the relationship to patient: _____

For completion by the Dentist

Comments on patient interview concerning medical history:
_____

Significant findings from the questionnaire or oral interview:
_____

Dental management considerations:
_____

Date: _____ Signature of Provider/Dentist: _____

Hackensack Meridian
Mountainside Medical Center

Mountainside Dental Department

STOP-BANG Sleep Apnea Questionnaire

Name: _____ Age: _____

Height: _____ Weight: _____ Gender: _____

STOP		
Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors?)	Yes	No
Do you often feel **T**IRED, fatigued, or sleepy during daytime?	Yes	No
Has anyone **O**BSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood **P**RESSURE?	Yes	No
BANG		
BMI more than 35? (please refer to the back of this page)	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 16 inches (40 cm)	Yes	No
Gender: Male?	Yes	No
TOTAL SCORE		

5-8: High risk of OSA/3-4: Intermediate risk of OSA/0-2: Low of risk of OSA

Body Mass Index

Height	Weight																				
	120	130	140	150	160	170	180	190	200	210	220	230	240	250	260	270	280	290	300	310	320
4'8"	27	29	31	34	36	38	40	43	45	47	49	52	54	56	58	61	63	65	67	69	72
4'9"	26	28	30	32	35	37	39	41	43	45	48	50	52	54	56	58	61	63	65	67	69
4'10"	25	27	29	31	33	36	38	40	42	44	46	48	50	52	54	56	59	61	63	65	67
4'11"	24	26	28	30	32	34	36	38	40	42	44	46	48	51	53	55	57	59	60	63	65
5'0"	23	25	27	29	31	33	35	37	39	41	43	45	47	49	51	53	55	57	59	61	62
5'1"	23	25	26	28	30	32	34	36	38	40	42	43	45	47	49	51	53	55	57	59	60
5'2"	22	24	26	27	29	31	33	35	37	38	40	42	44	46	48	49	51	53	55	57	59
5'3"	21	23	25	27	28	30	32	34	35	37	39	41	43	44	46	48	50	51	53	55	57
5'4"	21	22	24	26	27	29	31	33	34	36	38	39	41	43	45	46	48	50	51	53	55
5'5"	20	22	23	25	27	28	30	32	33	35	37	38	40	42	43	45	47	48	50	52	53
5'6"	19	21	23	24	26	27	29	31	32	34	36	37	39	40	42	44	45	47	48	50	52
5'7"	19	20	22	23	25	27	28	30	31	33	34	36	38	39	40	42	44	45	47	49	50
5'8"	18	20	21	23	24	26	27	29	30	32	33	35	36	38	40	41	43	44	46	47	49
5'9"	18	19	21	22	24	25	27	28	30	31	32	34	35	37	38	40	41	43	44	46	47
5'10"	17	19	20	22	23	24	26	27	29	30	32	33	34	36	37	39	40	42	43	44	46
5'11"	17	18	20	21	22	24	25	26	28	29	31	32	33	35	36	38	39	40	42	43	45
6'0"	16	18	19	20	22	23	24	26	27	28	30	31	33	34	35	37	38	39	41	42	43
6'1"	16	17	18	20	21	22	24	25	26	28	29	30	32	33	34	36	37	38	40	41	42
6'2"	15	17	18	19	21	22	23	24	26	27	28	30	31	32	33	35	36	37	39	40	41
6'3"	15	16	18	19	20	21	23	24	25	26	28	29	30	31	33	34	35	36	38	39	40
6'4"	15	16	17	18	19	21	22	23	24	26	27	28	29	30	32	33	34	35	37	38	39

Results: BMI below 18.5: Underweight BMI 18.5 to 24.9: Healthy weight BMI 25 to 29.9: Overweight BMI 30 or over: Obese

Hackensack Meridian
Mountainside Medical Center

Mountainside Dental Department Clinical Contract

Welcome to the Mountainside Dental Department. Listed below are the guidelines for ongoing treatment and your responsibility as a patient. The Dental department is open from 8:00 AM to 12:00 Noon and from 1:00 PM to 4:00 PM Monday through Friday by appointment. Emergency appointments are also scheduled daily by the receptionist. Patients are seen by *Dental Residents* who have graduated from Dental School and come to Hackensack Meridian Mountainside Medical Center Dental Department for an additional year of education. Our dentistry for the disabled department for special needs patients is run within the dental department. When the department is closed at night, weekends and holidays a dental resident is on-call in the Emergency Department for emergency evaluation and treatment.

Patient responsibility:

- **Keep all appointments** – please review "Late to appointment" and "Missed appointment or 'No-Show'" Protocols on the next page.
- **Arrive 15 minutes before your scheduled appointment.**
- **Bring photo identification and insurance cards at each visit, especially if your plan has any changes.**
- **Keep receipts of all payments made.**

Opportunities to become a patient of the Mountainside Dental Department are open a few times a year. Due to the high volume of active patients, a limited amount of patients will be accepted. A new patient package will be sent to each patient with instructions about the process of becoming a patient at the Hackensack Meridian Mountainside Medical Center Dental Department.

I understand the above guidelines for the dental department and agree to follow the rules.

Patient/ Guardian signature_____Date_____

Telephone Numbers
Dental Department (973)429-6887
Dentistry for the Disabled (973)429-6892 (Call on Mon, Tues, Wed for appointments to be scheduled)

ANETA WOJCIK, DDS
Director, Division of Dentistry

Hackensack Meridian
Mountainside Medical Center

Mountainside Dental Department

LATE TO APPOINTMENT PROTOCOL

At Mountainside Dental Department, we strive to see every patient as close to their appointment time as possible. Out of fairness to our patients who arrive on time to their appointment, we have implemented the following protocol.

If you arrive more than 10 minutes late to your appointment, you may be asked to reschedule. If there is an available opening for later that day, we will try to accommodate you at that time.

MISSED APPOINTMENT OR "NO-SHOW" PROTOCOL

We provide reminders 48 hours before your appointment, however, we understand that sometimes things come up that do not allow you to make your appointment. When patients cancel appointments without notice or fail to show up to appointments, it limits the availability of appointments for our other patients and disrupts the office workflow. Below is our no show protocol effective December 2018.

- To reschedule your appointment please call us at 973-429-6887 at least 24 hours in advance.
- After each missed appointment, we will send you a letter with our protocol and phone number asking you to reschedule.
- If you miss 3 consecutive appointments or 75% (3 out of 4) of all the appointments you had in one year, you will only be allowed to make same day appointments. This means you will need call the office at 8:30-9:30am to make an appointment for that day.
- If you continue to miss your same day appointments, you may be discharged from the practice and asked to find another provider that may be more accessible to your needs.
- You will receive a warning letter to alert you to the fact that you are in violation of the no show policy.

Patient/Guardian signature: _____ Date_____

Aneta Wojcik, DDS
Dental Director

Ronald Sirvent
Practice Manager