



Dear Patient:

Thank you for choosing the Dent Neurologic Institute, Western New York's premier Neurologic and Diagnostic Center.

Patients are required to arrive 30 minutes prior to their appointment time for the initial consultation. This time will be used to complete the registration process. Thank you for your understanding!

In order to ensure a positive experience, please be prepared with the following items on the day of your visit. Failure to comply may result in our need to reschedule your visit.

- ★ **Documents:** You must complete all the enclosed documents prior to your appointment time. **COMPLETION OF YOUR MEDICAL INTAKE FORMS IS CRITICAL IN ORDER FOR OUR PHYSICIANS APPROPRIATELY TREAT AND DIAGNOSIS.** If your visit is related to a work or motor vehicle accident, you must complete the application forms in their entirety.
- ★ **Insurance Card:** You must provide us with your insurance card.
- ★ **Payment:** If you have a co-pay or high deductible plan, you must bring payment with you; if you have a high deductible plan \$200 is required at the time of service; any remaining responsibility will be billed to you.
- ★ **Identification:** You must provide us with photo ID or two other forms of identification.
- ★ **Diagnostic Results:** Test results, diagnostic reports, films and CDs from all physicians treating you are **REQUIRED** at visit.

Be sure to visit our website at www.dentinstitute.com for insurances we accept and access to your on-line secured medical record.

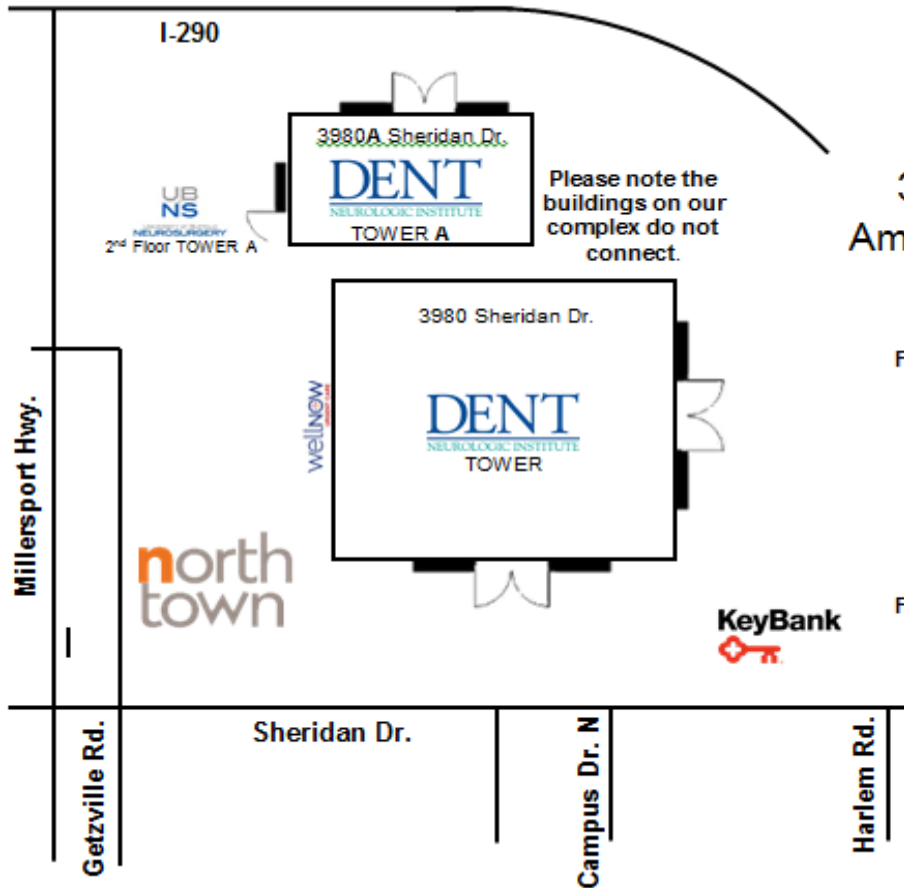
Once again, thank you for choosing the Dent Neurologic Institute. If you have any questions, please feel free to call our Center at 716-250-2000.

Advance Notice is Required for all Cancellations

If you fail to cancel an appointment at least one business day prior; or you do not show for your scheduled appointment, you will be assessed a non-timely cancellation fee.

Amherst Location

3980 Sheridan Drive
Amherst, New York 14226



DRIVING DIRECTIONS:

FROM NIAGARA FALLS/NORTHTOWN S

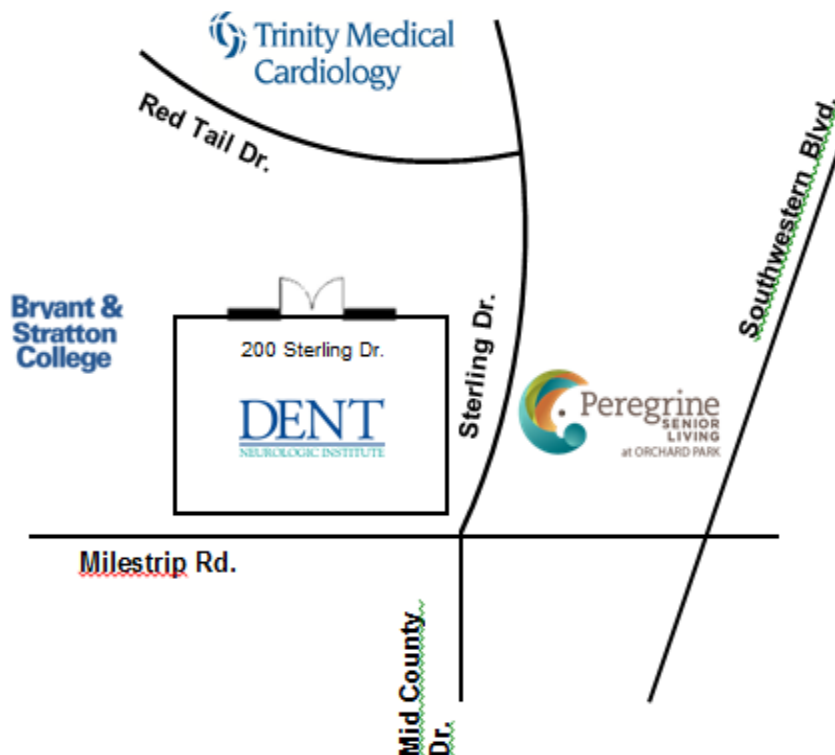
- Robert Moses Parkway South
- I-190 South
- I-290 East
- (Youngman Exp/Exit 16 to wards I-90)
- Exit Harlem Road (Exit 6)
- Right onto Harlem Road
- Left onto Sheridan Drive
- Right at light into Dent Tower

FROM SOUTHTOWNS

- I-190 East
- Merge into I-290
- (Youngman Exp/Exit 50)
- Exit Sheridan Drive (Exit 6)
- Left onto Sheridan Drive
- Right at light into Dent Tower

Orchard Park Location

200 Sterling Drive
Orchard Park, NY 14127



DRIVING DIRECTIONS:

FROM SOUTHTOWNS

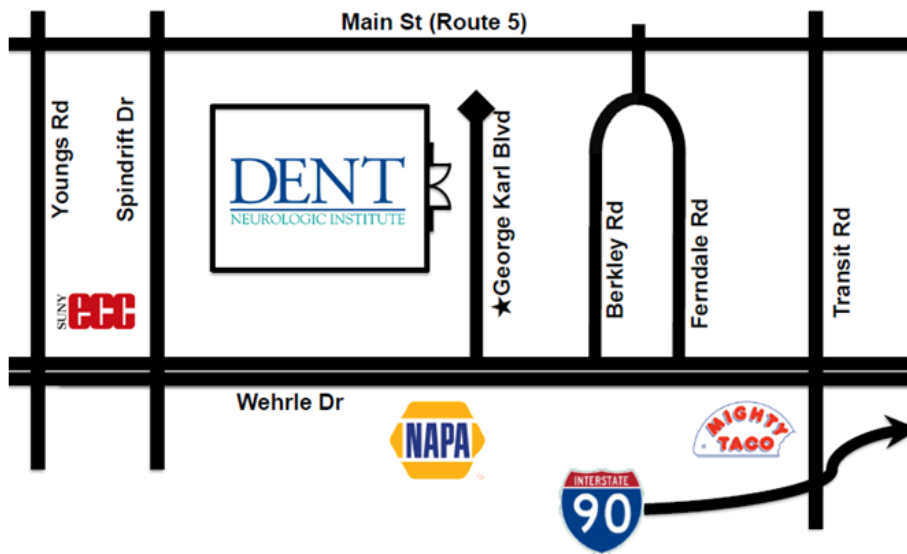
- Route 219 N to Milestrip Road East
- (1st Exit onto Milestrip Road)
- Left at traffic light onto Sterling Drive
- Left on Red Tail
- Left into parking lot

FROM BUFFALO

- Thruway (90) West to Route 219
- Exit Milestrip Road East
- (2nd Exit onto Milestrip Road)
- Left at traffic light onto Sterling Drive
- Left on Red Tail
- Left into parking lot

FROM PENNSYLVANIA

- Thruway (90) East to Exit 56
- Left onto Milestrip Road
- Left onto Sterling Drive
- Left on Red Tail
- Left into parking lot



Buffalo Location
40 George Karl Boulevard
Buffalo, NY 14221
Suite 120

From Niagara Falls

- I-190 South toward Buffalo
- Exit 16 for I-290 East toward Rochester/ Tonawanda
- Take ramp left for Thruway I-90 East toward Albany (*Toll road)
- Exit 49 for Transit Rd.
- Turn left onto Transit Rd.
- Turn left onto Wehrle Dr.
- Turn right onto George Karl Blvd.
- Turn left into parking lot

From Buffalo

- Route 33 East toward Airport
- Take ramp right for Thruway I-90 East toward Albany (*Toll road)
- Exit 49 for Transit Rd.
- Turn left onto Transit Rd.
- Turn left onto Wehrle Dr.
- Turn right onto George Karl Blvd.
- Turn left into parking lot

From Southtowns

- Route 219 North toward Buffalo
- Take ramp right for Thruway I-90 East toward Buffalo (*Toll road)
- Exit 49 for Transit Rd.
- Turn left onto Transit Rd.
- Turn left onto Wehrle Dr.
- Turn right onto George Karl Blvd.
- Turn left into parking lot

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DENT NEUROLOGIC INSTITUTE

REGISTRATION FORM

Today's Date:			
PATIENT INFORMATION			
Last Name:		Middle:	First Name:
<input type="checkbox"/> Mr. / <input type="checkbox"/> Mrs. / <input type="checkbox"/> Miss / <input type="checkbox"/> Ms.		Marital Status (Check one):	<input type="checkbox"/> Single / <input type="checkbox"/> Married / <input type="checkbox"/> Divorced <input type="checkbox"/> Separated / <input type="checkbox"/> Widowed
Former Name:		Preferred Name:	
Birth Date:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	E-mail Address:	
Home Phone: ()		Cell Phone: ()	
Street Address or P.O. Box:			
City:	State:	Zip Code:	Social Security Number:
Primary Physician:		Referring Physician:	
Race:	Ethnicity:	Language:	
Pharmacy Name:	Pharmacy Address:	Pharmacy Phone:	
CONTACT PERSON IN CASE OF EMERGENCY			
Name:		Relationship:	
Home Phone: ()		Cell Phone: ()	
SEXUAL ORIENTATION / GENDER IDENTITY			
Sexual Orientation (Check one):	<input type="checkbox"/> Lesbian, gay or homosexual / <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Bisexual / <input type="checkbox"/> Do not know / <input type="checkbox"/> Choose not to disclose		
	Something else, please describe:		
Gender Identity (Check one):	<input type="checkbox"/> Male / <input type="checkbox"/> Female / <input type="checkbox"/> Female-to-Male (FTM), Transgender Male, Trans Man <input type="checkbox"/> Male-to-Female (MTF), Transgender Female, Trans Woman <input type="checkbox"/> Genderqueer, neither exclusively male nor female <input type="checkbox"/> Choose not to disclose		
	Additional gender category or other, please specify:		

DENT NEUROLOGIC INSTITUTE

INSURANCE INFORMATION

You will need to give your insurance card to the receptionist			
Person Responsible for Bill (if not self):	Address (if different):	Home Phone: ()	
		Cell Phone: ()	
Birth Date: / /	Occupation:		
Responsible Party's Employer:	Employer Address:	Employer Phone: ()	
PRIMARY INSURANCE	Insurance Plan:		
Policy No:	Group No:		
Subscriber's Name (if not self):	Subscriber's SSN:		Co-pay Amount:
	Subscribers DOB: / /		
Patient's Relationship to Subscriber (Check one):	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child <input type="checkbox"/> Other
SECONDARY INSURANCE	Insurance Plan:		
Policy No:	Group No:		
Subscriber's Name (if not self):	Subscriber's SSN:		
	Subscribers DOB: / /		
Patient's Relationship to Subscriber (Check one):	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child <input type="checkbox"/> Other

**IF YOUR APPOINTMENT IS THE RESULT OF AN ACCIDENT OR INJURY,
YOU MUST COMPLETE THE ENCLOSED NO-FAULT OR WORKERS COMP FORM**

PLEASE READ

Important Insurance Plan Information

Before being seen, please review the following insurance participation information. Deductibles, co-insurances and co-pays are due at time of service. Estimated cost of an office visit ranges from \$75 - \$200; estimates for office procedures will be provided separately. If you have any questions or would like to receive an estimate for services, please call our Business Office at 250-2010.

DENT Participates with:

- Blue Cross Blue Shield (including Align programs)
- Empire
- Fidelis (**Not Accepting New Adult Patients**)
- Independent Health
- MagnaCare (including Health Republic)
- MVP (excluding Individual Exchange plans)
- Nova
- RMSCO (aka Lifetime Benefits Solutions)
- United Healthcare (Commercial and Medicare plans only)
- Univera
- Medicare and Medicare Railroad
- NYS Medicaid
- Wellcare (**Not Accepting New Patients**)
- Excellus - Blue Cross Plans (does not include Medicare Blue Choice Value/ Optimum or Monroe Medicaid plans)
- Martin's Point (varies by doctor)
- YourCare

DENT does NOT Participate with:

- Aetna (unless part of MultiPlan which varies by doctor)
- Cigna (unless part of MultiPlan which varies by doctor)
- Coventry/Health America
- Emblem Health/GHI -Imaging ONLY
- Excellus Plans (Premier Option)
- MVP (Individual Exchange plans)
- MultiPlan (varies by doctor)
- UPMC
- United Healthcare (Medicaid plans)
- Out of State Medicaid

In every case we will bill your insurance carrier on your behalf. Based on participation status you may have additional out-of-pocket expenses. We recommend you call your carrier directly to verify individual physician coverage.

Your insurance carrier may require you to utilize a specific laboratory testing facility. Please be sure to confirm this with the office staff.

Hospital Affiliations: Kaleida Health; Mercy Hospital of Buffalo

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DENT NEUROLOGIC INSTITUTE
WORKERS COMPENSATION
 SUPPLEMENTAL INFORMATION FORM

Today's Date:		Date of Birth:	
Patient Name:		Social Security No:	
Date of Injury:			
Employer Name:		Employer Address:	
Employer Phone Number: ()	Your Job Title:	Are you out of work due to this injury: <input type="checkbox"/> Yes <input type="checkbox"/> No	

COMPENSATION INSURANCE CARRIER INFORMATION

Insurance Carrier Name:		Insurance Carrier Address:	
Carrier Claim Number:		WCB Case Number:	
Name of Case Manager:		Phone: ()	
		Fax: ()	
Briefly Describe the Injury you Sustained:			
Briefly Describe how Injury Occurred:			

ATTORNEY INFORMATION

Attorney Name:		Attorney Address:	
Phone: ()		Fax: ()	

Please bring all Insurance Carrier and Workers Compensation Board information with you to your appointment. We may need to reschedule your appointment should you fail to include critical information concerning your Carrier.

DENT NEUROLOGIC INSTITUTE

NO-FAULT

SUPPLEMENTAL INFORMATION FORM

Patient Name:	Date of Birth:
	Social Security No:
Date of Accident:	Are You Currently Out of Work as a Result of this Accident: <input type="checkbox"/> Yes <input type="checkbox"/> No
Injury Sustained:	
INSURANCE CARRIER INFORMATION	
Insurance Carrier Name:	Insurance Carrier Address:
Name of Adjuster:	Claim Number:
Phone: ()	Fax: ()
ACCIDENT DETAILS	
Location of Accident:	
Briefly Describe how the Accident Occurred:	
Were you a: <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian	
If Driver or Passenger, were you: <input type="checkbox"/> Belted <input type="checkbox"/> Not-Belted	
Have you Filed a Claim with your Carrier: <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you Completed and Returned your No-Fault Application: <input type="checkbox"/> Yes <input type="checkbox"/> No
ATTORNEY INFORMATION	
Attorney Name:	Attorney Address:
Phone: () Fax: ()	
Signature:	Date:
FOR OFFICE USE ONLY	
PROVIDER: DENT NEUROLOGIC GROUP PO Box 8000 Dept 057 Buffalo, NY 14267 Signature: _____	CLAIM# _____ DATE OF LOSS: _____ CARRIER: _____

DENT NEUROLOGIC NEW PATIENT HISTORY FORM

Today's Date _____

Name: _____

DOB: _____

Age: _____

1. Please describe the problem that you would like addressed, e.g., what it consists of, how and when it started, what worsens and relieves it.

- 2a. Who is your **primary physician with address** (if known)?

- 2b. What physicians have you seen for this problem?

3. List all illnesses and/or hospitalizations/surgeries you have had during your life:

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

4. List the name and dose for each prescription and over-the-counter medication you are currently taking:

Drug:	Dose:
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

5. Any drug allergy?

<u>Drug</u>	<u>Reaction</u>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

6. What has been done for your problem? Medications? Physical therapy? Surgery? Other?

<u>Treatment</u>	<u>Date</u>	<u>Results</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Other problems? Please **circle** the ones that apply to you:

Neurologic

Headache, change in taste, smell or hearing, slurred speech, difficulty swallowing, dizziness, weakness, numbness, loss of consciousness, fainting, seizure, unsteadiness, falls, tremor, confusion, memory loss, head trauma, sleep problem, stroke/TIA (mini-stroke)

Constitutional

Fever, chills, fatigue, weight gain or loss, HIV/AIDS

Eyes

Blurry vision, double vision, decreased vision, cataract, glaucoma

Ears, Nose, Mouth, Throat

Hearing loss, ringing in the ears, earache, hoarseness, vertigo (spinning)

Cardiovascular

Chest pain, palpitations, leg edema, high blood pressure, heart attack, coronary artery disease/surgery, shortness of breath when lying down or on exertion, heart failure.

Respiratory

Cough, emphysema, asthma.

Gastro-Intestinal

Nausea, vomiting, heartburn, ulcers, abdominal pain, diarrhea, constipation, hepatitis

Genito-Urinary

Urinary incontinence/frequency/urge, sexual dysfunction, kidney problems

Skin

Rash or other skin abnormality

Musculoskeletal

Joint pain/swelling/stiffness, neck/lower back pain, muscle aches

Psychiatric

Depression, anxiety, other psychiatric problems

Print Name: _____

Continued from # 7

Endocrine

Diabetes, thyroid problems, hormonal problems

Hematologic

Anemia, easily bruises, bleeding disorder.

Allergy

Itching, rash, swollen lips/tongue.

Have you ever had cancer? ___ No ___ Yes, describe _____

8. Have you had any of the following tests?

<u>Test</u>	<u>Date</u>	<u>Where</u>
MRI	_____	_____
CT	_____	_____
Carotid Doppler	_____	_____
EMG	_____	_____
EEG	_____	_____
SPECT/PET	_____	_____
Other (myelogram, angiogram, biopsy, spinal tap):		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

9. Do you use tobacco? ___ No ___ Yes, pack per day ____, # of years ____ Quit date _____

Do you use alcohol? ___ No ___ Yes, amount _____

Who lives with you at home? _____

Describe your work: _____

Disability? _____ No _____ Yes, since _____

10. Have you fallen in the past 12 months? ___ No ___ Yes

Do you feel unsteady when standing or walking? ___ No ___ Yes

Print Name: _____

11. Tell us about your family's health:

Mother:	_____		
Father:	_____		
Brother #1:	_____	Sister #1:	_____
Brother #2:	_____	Sister #2:	_____
Brother #3:	_____	Sister #3:	_____
Brother #4:	_____	Sister #4:	_____

12. What do you hope to achieve with your doctor?

13. Emergency contact:
Name: _____ Relationship: _____
Phone: _____ Mobile Phone: _____

Print Name

Signature

Date

Tell Us How We're Doing!
Visit Our Website at www.dentoinstitute.com and take our online survey

For office use only:

BP _____ Pulse _____ Resp. _____ Wt. _____ Ht. _____