Hackensack Meridian
Mountainside Medical Center

Dear Patient,

We can't wait to see you soon. Oral health is a gateway to your overall health, and your health is our top priority. As you might have imagined, things will be a little different this visit. To keep you safe and smiling, our practice is adhering to the American Dental Association's guidelines for providing dental care during the COVID-19 pandemic.

Here is what you can expect:

- Before your appointment
  - We will contact you prior to your visit to check on your current health status
  - You will be asked to limit the number of people you bring to your appointment (this could entail leaving your children at home or having older children go into the office alone)

- When you arrive
  - Enter through the Harries Pavilion where you will be cleared to enter the hospital
  - You will have additional screenings upon entering the dental department

- During your appointment
  - For your safety and ours, you will be asked to wear a mask
  - Your temperature will be taken
  - The dental team will wear additional personal protective equipment (PPE), including face masks, plastic face shields, goggles and surgical gowns or long-sleeved lab coats

- After your appointment
  - To prepare for the next patient, staff will thoroughly clean the areas you have been in using cleansers specifically designed to deactivate the COVID-19 virus
  - If you experience COVID-19 symptoms into 48 hours following your appointment, please contact us at 973-429-6887

All of this is done with your health as our utmost priority. You can rest assured that we are taking every precaution to ensure that our office is optimized for maximum safety. Please feel free to contact us with any questions or concerns you have about your visit.

We look forward to seeing you!

Sincerely,
Aneta Wojcik, D.D.S,

Medical Director Dental Program

Hackensack Meridian
Mountainside Medical Center

Dear Patient:

Thank you for your interest in becoming a patient at our dental clinic. Here are the steps on how to become a patient:

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 copy of current insurance card.
3. Include copy of a valid photo ID (NJ driver's license, passport or green card) if minor, copy of parent's valid photo ID.
   Mail to Hackensack Meridian Health Mountainside Medical Center, Division of Dentistry, 1 Bay Avenue Montclair, NJ 07042.

Paperwork will be *discarded* if:

1. It has not properly completed and signed.
2. Requested copies are not attached.
3. Received after due date.

After submitting your forms, we will contact you for an appointment. Only one attempt will be made due to the high volume of patient. If a message is left by the *Dental Clinic*, the patient/guardian will have up to 10 days to make an appointment if not the application will no longer be valid.

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

Division of Dentistry Clinical Contract

Welcome to the dental clinic. Listed below are the guidelines for ongoing treatment and your responsibility as a patient. The Dental clinic 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 Health Mountainside Medical Center Dental Clinic for an additional year of education. Our dentistry for the disabled clinic for special needs patients is run within the dental clinic. When the clinic 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. *24-hour notice is required for changing appointments. If 24 hours notice is not given this is marked as a missed appointment.*

Be on time for you appointments. *Allow extra time for travel, parking especially in bad weather and for COVID-19 Screenings. If you are more than 10 minutes late for an appointment, this will count as a missed appointment. We will try to see you if you are late but that may not be possible.*

Alternate scheduling

If 2 appointments are missed or cancelled with less than 24 hours notice in a period of 6 months you will be placed on alternative scheduling. Only certain limited days for appointment will be given. You must call the day before the alternative scheduling date to confirm. If missed appointments continue you will be asked to find another site for dental treatment.

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 dental clinic 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 patient with instructions about the process of becoming a patient at the Hackensack Meridian Health Mountainside Medical Center Dental Clinic.

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

Patient/ Guardian signature_____Date_____

Telephone Numbers
Dental Clinic (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

MOUNTAINSAIDE DENTAL CLINIC

LATE TO APPOINTMENT PROTOCOL

At Mountainside Dental Clinic, 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 will likely 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. 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's signature: _____

Aneta Wojcik, DDS
Dental Director

Ronald Sirvent
Practice Manager

Hackensack Meridian
Mountainside Medical Center

Dental Clinic

PLEASE PRINT

PATIENT NAME: (LAST, FIRST) _____ DATE OF BIRTH: _____

PATIENT GENDER: Male _____ Female_____ Patient S.S. # _____-_____-_____ MR# _____

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

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMAIL: _____

RACE: _____ LANGUAGE: _____ WEIGHT_____ HEIGHT: _____

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:

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:

MEDICAID CCN#: _____ MEDICAID ID#: _____

AETNA BETTER HEALTH ID#:_____AMERIGROUP ID#: _____

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

WELLCARE ID#:_____

Hackensack Meridian
Mountainside Medical Center

Outpatient Assessment

Patient name

Date of Birth

GRAY Boxes for Hospital Use only

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?		

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?		
Seizure?		
Tranquilizers?		
Sleeping pills?		
Pain pills prescribed by your doctor?		
Blood Pressure Pills?		
Laxatives?		
Do you have any of these health conditions:		
Problems with your vision?		
Sudden and urgent need to urinate**?**		
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?		
Are you being hurt or threatened by anyone?		

Social Service Referral information given:
Yes NA refused

Patient/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 Physician:

_____

_____

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? _____ Yes No
4. Are you now under the care of a physician _____ Yes No
   If so, 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 so, what was the illness or problem? _____
6. Are you taking any medication(s) including non-prescription medicine? _____ Yes No
   If so, what medicine(s) ae you taking? _____
   _____
7. Do you have or have you had any of the following disease problems?
   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. 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. Cancer _____ Yes No
   i. Epilepsy (seizures) or other neurological disease _____ Yes No
   j. Psychiatric problems (depression, anxiety, bipolar disorder) _____ Yes No
   k. Mental Retardation _____ Yes No
   l. ADD/ADHD, Autism _____ Yes No
8. Do you bruise easily or have abnormal bleeding? _____ Yes No
9. Have you ever had any treatment for a tumor or growth? _____ Yes No
10. Do you have osteoporosis? _____ Yes No
11. Do you take or have you ever taken any Bisphosphonate medication? _____ Yes No

If so, which ones? _____

12. Are you allergic or have you had a reaction to:

a. Local anesthetics _____ Yes No
b. Penicillin or other antibiotics _____ Yes No
c. Aspirin _____ Yes No
d. Codeine or other narcotics _____ Yes No
e. Latex _____ Yes No
f. Other _____ Yes No

13. Do you smoke cigarettes? _____ Yes No

If so, how much? _____

14. Do you use any recreational drugs? _____ Yes No

If so, which one? _____

15. How often and how much alcohol do you consume? _____Never _____ Daily _____ Weekly _____ Monthly

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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 so, 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 Dentist: _____

Hackensack Meridian
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Dental Clinic

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

Intermediate risk

of risk of OSA

Hackensack Meridian
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OSA/3-4:

of OSA/0-2: Low

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