PERSON TO CONTACT IN CASE OF EMERGENCY

Name: _____

Address: _____

_____

Phone #: _____

Secondary Emergency Contact:

Name: _____

Address: _____

_____

Phone #: _____

Is there anything else that we should include in your patient record:

_____

_____

_____

_____

_____

_____

_____

_____

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_____

_____

_____

FINANCIAL POLICY

As you may know, your dental insurance does not always cover the cost of your treatment. In these instances, you may be financially responsible for your treatment. To keep our fees to you as low as possible, we ask that you pay your co-payment at the time you receive treatment. Please indicate the method you intend to use to pay for your dental treatment, including your co-payment:

☐ Credit Cards ☐ Checks ☐ Cash

☐ I would like to know more about financing my treatment

_____

Signature of ☐ Patient or ☐ Guardian

For Patients with Insurance

By signing below I hereby authorize this office to affix my name to any and all claims or documents as related to any and all health benefits due to me and my dependents through my employment. I hereby authorize payment of dental benefits otherwise payable to me, directly to this dental office. This "Signature on File" will be valid from this date and shall expire in one year or unless I cancel the authorization through written notice to this office. A photocopy of this document may act as an original. Please understand this account is still your responsibility.

_____

"Signature on File" Effective Date

NOTICE

Balances over 60 days old are subject to an interest charge of 1.5% per month (annual rate 18%)

Thank You for completing this Patient Information Form!

Williamsburg DENTAL

Dentistry Is Our Passion.
Service Is Our Obsession.

We would like to get to know you better!

Today's Date: _____

Name: _____

Address: _____

City: _____ St: ____ Zip: _____

Telephone numbers:

Home: _____ ☐ best

Work: _____ ☐ best

Cell: _____ ☐ best

Date of Birth: _____

SS#: _____

E-mail: _____

Whom may we thank for referring you to our office:

☐ I saw your sign ☐ Yellow pages

☐ My Friend _____

☐ My Family ☐ Advertisement

Who will be responsible for your financial arrangements?

Name: _____

For Primary Insurance Purpose

Insured's Name: _____

Employer: _____

Insurance carrier: _____

Group Number: _____

Insured's Date of birth:

_____

Insured's SS#: _____

Thank You!

❑ Dr. Joseph Capista

❑ Dr. Joseph Lamb

❑ Dr. Robert Spennato

❑ Dr. Daniel Tibbetts

Dental / Medical History

	Yes	No
Do you have a specific dental concern today?	☐	☐

*If yes, describe*_____

_____

_____

_____

_____

	Yes	No
Are your teeth sensitive to		
Heat?	☐	☐
Cold?	☐	☐
Sweets?	☐	☐
Biting Pressure?	☐	☐
Does food catch between your teeth?	☐	☐
Do your gums bleed when brushing?	☐	☐
Have you noticed any swelling around any teeth?	☐	☐
Do you ever avoid any part of the mouth while brushing?	☐	☐

Where? _____

Are you dissatisfied with the appearance or color of your teeth?	☐	☐
Do you want to learn to control dental disease and retain your teeth?	☐	☐
Do you have an unpleasant taste or odor in your mouth?	☐	☐
Do you smoke or chew tobacco?	☐	☐
Do you have missing teeth that you are concerned about?	☐	☐

How long have these teeth been missing?

☐ Recently ☐ _____ago

When was your last set of x-rays? _____

When was your last dental appointment?

Approximate date: _____

Do you need to premedicate for any reason?	☐	☐

	Yes	No
Have you ever had a reaction to local anesthetic?	☐	☐
Do you have any general health problems?	☐	☐

If so, please specify _____

_____

_____

Have you ever had Surgery?	☐	☐

If so, please specify _____

_____

_____

Are you currently under a physician's care?	☐	☐

Reason: _____

_____

_____

Are you taking any medications at this time?	☐	☐

If so, please specify _____

_____

_____

To the best of your knowledge, are you or have you ever been affected with:

Heart Murmur/MVP	☐	☐
Heart Ailment	☐	☐

If so, please specify _____

_____

Asthma	☐	☐
Diabetes	☐	☐
Rheumatic Fever	☐	☐
High Blood Pressure	☐	☐
Respiratory Disease	☐	☐
Hepatitis Type: _____	☐	☐
Prolonged Bleeding	☐	☐
Healing Complications	☐	☐
Allergy to any Drugs	☐	☐

If yes, please specify: _____

Are you Pregnant	☐	☐

Month _____

	Yes	No
HIV / AIDS	☐	☐
Joint Replacement	☐	☐

Why did you leave your last dentist?

_____

What are your present dental problems?

_____

_____

To the best of my knowledge, all of the proceeding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and/or staff at the next appointment without fail. I hereby authorize the dental office to administer such medication and perform diagnostic and therapeutic procedures as may be necessary for proper dental care. I grant the right of the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health care professionals.

_____

Signature of ☐ Patient or ☐ Guardian Date

Dental / Medical History Update

My information has changed in the following way:

	Yes	No
Any Medications:	☐	☐

Specify: _____

_____

_____

New Allergies:	☐	☐

Specify: _____

_____

Physical Health / Hospitalization	☐	☐

Specify: _____

_____

Other	☐	☐

Specify: _____

_____

Address: _____

_____

Phone #: ☐ Home _____

☐ Other:_____

To the best of my knowledge, the updated answers are correct. I will continue to notify the office of any changes in my health status or if my medicines change without fail.

_____

Signature of ☐ Patient or ☐ Guardian Date