Welcome to our office. We appreciate and value the opportunity to be your dental care provider and look forward to working with you to understand your needs and to deliver the care you desire. We pride ourselves on making your entire dental experience pleasant and always strive to justify your confidence in our team.

(518) 374-0317 • info@capitalsmiles.com • 1541 Union St. • Schenectady, NY 12309

1. PATIENT INFORMATION

Last Name: _____

First Name: _____ Middle Initial: _____

Social Security #: _____ DOB: _____

Cell Phone #:_____ Home #:_____

Work Phone#:_____

In Case of Emergency, Contact: _____

Emergency Contact Phone #:_____

Sex: Male Female

Please circle: Married Widowed Single Minor

Address: _____

City: _____ State: _____

Zip: _____

E-mail: _____

Patients School/Employer: _____

Occupation: _____

School/Employer address:

_____

_____

School/Employer Phone: _____

Whom may we thank for referring you to our office?

_____

2. INSURANCE

Responsible Party: _____

Relationship to patient: _____

Insurance Company: _____

Group #:_____

Subscriber's Name: _____

Subscriber's Birthday: _____

Subscriber's ID or SSN #: _____

Subscriber's Employer: _____

I assign directly to Capital Smiles all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Capital Smiles may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits. Additionally, by signing this form I authorize Capital Smiles to process credit card transactions initiated by me either by phone or by mail and I authorize my credit card institution to pay.

_____
Name of Patient or Responsible Party

_____
Signature of Patient or Responsible Party

_____
Date

3. DENTAL HISTORY

Reason for today's visit: _____

Former Dentist: _____ City/State: _____

Date of last visit: _____ Date of last dental x-rays: _____

For the following, please circle yes or no:

Bad breath	No	Yes	Fingernail biting	No	Yes	Mouth breathing	No	Yes
Bleeding gums	No	Yes	Food between teeth	No	Yes	Mouth pain, brushing	No	Yes
Blisters on lips/ mouth	No	Yes	Foreign objects	No	Yes	Orthodontic treatment	No	Yes
Burning sensation-tongue	No	Yes	Grinding teeth	No	Yes	Pain around ear	No	Yes
Chew on one side	No	Yes	Gums swollen/tender	No	Yes	Periodontal treatment	No	Yes
Cigarette, pipe, cigar	No	Yes	Jaw pain/tiredness	No	Yes	Sensitivity hot/cold	No	Yes
Clicking/popping of jaw	No	Yes	Lip/cheek biting	No	Yes	Sensitivity sweet/biting	No	Yes
Dry mouth	No	Yes	Loose teeth/ filling	No	Yes	Sores/growths in mouth	No	Yes

How often do you brush? _____ How often do you floss? _____

Current Weight: _____ (for determining proper does of medication)

Rate your dental anxiety level 1-10: Minimum 1 2 3 4 5 6 7 8 9 10 Maximum

4. HEALTH HISTORY

Physician's Name: _____ Date of Last Visit: _____

Office Address: _____ Office Phone #: _____

Specialist's Name: _____ Date of Last Visit: _____

Office Address: _____ Office Phone #: _____

Other Doctor: _____ Date of Last Visit: _____

Office Address: _____ Office Phone #: _____

Medications you are currently taking and reasons for taking: **(including vitamins and supplements)**

_____

_____

_____

Pharmacy Name, Phone #, and Address: **(please include zip-code)**

_____

Allergies: For the following, please circle yes or no:

Aspirin	No Yes	Iodine	No Yes	Penicillin	No Yes
Barbiturates	No Yes	Latex	No Yes	Sulfa	No Yes
Codeine	No Yes	Local Anesthetic	No Yes	Epinephrine Sensitivity	No Yes

Other _____

Conditions: For the following, please circle yes or no:

AIDS/HIV	No Yes	Fainting/dizziness	No Yes	Shortness of breath	No Yes
Anemia	No Yes	Glaucoma	No Yes	Sinus trouble	No Yes
Arthritis, Rheumatism	No Yes	Headaches	No Yes	Skin rash	No Yes
Artificial heart valves	No Yes	Heart murmur	No Yes	Special diet	No Yes
Artificial joints	No Yes	Heart problems	No Yes	Stroke	No Yes
Asthma	No Yes	Hepatitis type ____	No Yes	Swollen feet	No Yes
Back problems	No Yes	Herpes	No Yes	Swollen neck glands	No Yes
Bleeding abnormally	No Yes	High blood pressure	No Yes	Thyroid problems	No Yes
Blood transfusion	No Yes	Jaundice	No Yes	Tonsillitis	No Yes
Bruising Easily	No Yes	Jaw pain	No Yes	Tuberculosis	No Yes
Blood disease	No Yes	Kidney disease	No Yes	Tumor/growth	No Yes
Cancer	No Yes	Liver disease	No Yes	Ulcer	No Yes
Chemical Dependency	No Yes	Low blood pressure	No Yes	Venereal disease	No Yes
Chemotherapy	No Yes	Mitral valve prolapse	No Yes	Weight loss	No Yes
Circulatory Problems	No Yes	Nervous problems	No Yes	Osteoporosis	No Yes
Congenital heart lesions	No Yes	Pacemaker	No Yes	COPD	No Yes
Cortisone treatments	No Yes	Psychiatric care	No Yes	Congestive Heart Failure	No Yes
Cough	No Yes	Radiation therapy	No Yes	Chronic pain	No Yes
Diabetes type ____	No Yes	Respiratory Disease	No Yes	Gastric bypass	No Yes
Emphysema	No Yes	Rheumatic fever	No Yes	Bariatric surgery	No Yes
Epilepsy	No Yes	Scarlet fever	No Yes	Restricted diet	No Yes

Are you currently being treated for any other condition? **No Yes** (please list) _____

Have you been hospitalized (or had surgery) in the last 5 years? **No Yes** If "yes" please describe nature of care:

_____

a. Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, and Boniva. **Please circle: No Yes**

b. Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). **Please circle: No Yes**

c. Are you currently taking aspirin? **Please circle: No Yes** _____ mg/day

d. **Women:** Are you a nursing mother? **Please circle: No Yes** Are you pregnant? **No Yes** Due date: _____
If no, are you planning a pregnancy in the near future? **No Yes**

Capital Smiles
Erin M. Page DDS, PC

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges a copy of the currently effective Notice of Privacy Practices for this healthcare facility is available upon request and on our website (capitalsmiles.com). A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACITILYS IN THE FUTURE.**

_____ _____
Printed Name Signed Name

_____ _____
Legal Representative, if applicable Relationship, if applicable

HOW DO YOU WANT TO BE ADDRESSED WHEN CALLED FROM THE RECEPTION AREA?

□ First Name Only □ Proper Surname □ Other: _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLINGS INFORMATION VIA:**

□ Cell Phone Confirmation
□ Home Phone Confirmation
□ Work Phone Confirmation
□ Text Message to Cell Phone
□ Email Confirmation
□ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:**

□ Cell Phone Confirmation
□ Home Phone Confirmation
□ Work Phone Confirmation
□ Text Message to Cell Phone
□ Email Confirmation
□ **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

□ It was emergency treatment
□ The patient refused to sign
□ I could not communicate with patient
□ Other: _____

Privacy Officer Signature: _____

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Erin M. Page DDS, PC

ACKNOWLEDGEMENT OF APPOINTMENT SCHEDULING AND CANCELLATION POLICIES

When you schedule an appointment at Capital Smiles your appointment time is reserved exclusively for you. Canceling an appointment without adequate notice results in a block of time which could have been used to deliver care to another patient.

Our schedule is booked several months in advance, and when an appointment becomes available due to a cancellation there are patients who would like the opportunity to move their appointment up sooner. **When scheduling an appointment at Capital Smiles you are offered the first available time of your preference. If you would like to come in sooner than what is available, please let our office know and you will be put on a call list for when a cancellation may arise.**

OUR SCHEDULING AND CANCELLATION POLICIES:

- An appointment longer than one hour or with a cost of more than $1,000 requires a $200 deposit at the time of scheduling. We ask that 48 hours' notice be given to reschedule this appointment. **If less than 24 hours' notice is given because of an unforeseen and unavoidable event, your deposit will be forfeited.** We will try our best to fill the opening with an appointment for another patient, and in that event the deposit will be credited back to your account.

- Appointments scheduled with intravenous or oral conscious sedation require a $495 deposit. A two-week notice must be given to reschedule a full day appointment, and a one-week notice must be given to reschedule a half day or less appointment in order for the deposit to be transferable, **otherwise the deposit is forfeited.**

- We ask that 48 hours' notice be given to reschedule all other appointments. We understand that last minute unforeseen events can arise that do not allow for 48 hours' notice. **A $50 cancellation fee will be charged for any appointment canceled with less than 24 hours' notice and is due at the time of the cancellation.** In the event that your appointment time is filled by another patient, the $50 charge will be credited to your account.

_____ _____

Name of Patient or Responsible Party Signature of Responsible Party

_____

Date

Financial Policy

Patient Name (print) _____

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment . Payment is due at the time service is provided. Our office accepts cash, personal checks, credit cards and outside patient financing.

Please check if you would like more information about financing options. ☐

Please Note: Returned checks will be subject to additional fees. If you fail to pay the office on time and it refers your account(s) to a third party for collection, a collection fee of 25% will be assessed and will be due at the time of the referral to the third party. If your account(s) are referred to an attorney or legal action is taken to recover the account(s) a collection fee of 35% will be assessed and will be due at the time of the referral to an attorney or legal action is taken. Such fee will not be assessed in states where it is prohibited by law.

Do You Have Insurance?

- We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card or Patient Financing at the time we provide the service to you.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any question you may have concerning your care or our financial policy.

Consent:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office.I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

_____ _____

Patient Signature (Parent if child) *Date*