Creating a Better Capital Smiles
Shilch Lieberman DDS
Erin M. Page DDS
Dental Experience

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:

_____

_____

_____

Pharmacy Name, Phone #, and Address:

_____

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 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**