



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: \_\_\_\_\_

Address: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_

Zip: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_ Home #: \_\_\_\_\_

E-mail: \_\_\_\_\_

Work Phone#: \_\_\_\_\_

Patients School/Employer: \_\_\_\_\_

In Case of Emergency, Contact: \_\_\_\_\_

Occupation: \_\_\_\_\_

Emergency Contact Phone #: \_\_\_\_\_

School/Employer address: \_\_\_\_\_

Sex: Male Female

\_\_\_\_\_  
 \_\_\_\_\_

Please circle: Married Widowed Single Minor

School/Employer Phone: \_\_\_\_\_

Whom may we thank for referring you to our office?  
 \_\_\_\_\_

**2. INSURANCE**

Responsible Party: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Subscriber's Birthday: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Subscriber's ID or SSN #: \_\_\_\_\_

Group #: \_\_\_\_\_

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 doses 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:

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Pharmacy Name, Phone #, and Address:

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**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**

# Capital Smiles

Erin M. Page DDS, PC  
Shiloh Lieberman DDS, LLC

## 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/FACILILYS 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 Sir Name                       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:**

- |  |   |
|--|---|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation         |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> <b>Any of the Above</b>    |

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

- |  |   |
|--|---|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation         |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> <b>Any of the Above</b>    |

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.

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#### Office Use Only

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

- |  |   |
|--|---|
| <input type="checkbox"/> It was emergency treatment  | <input type="checkbox"/> I could not communicate with patient |
| <input type="checkbox"/> The patient refused to sign | <input type="checkbox"/> Other: _____                         |

Privacy Officer Signature: \_\_\_\_\_