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 | capitalsmiles@mydentalmail.com | 1541 Union St. Schenectady NY 12309

PATIENT INFORMATION

First Name: _____ Last Name: _____

Birth Date: _____ Gender: ◯ Male ◯ Female ◯ Other: _____

Address: _____

City: _____ State: _____ ZIP _____

Email: _____ Cell Phone: _____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Other

Emergency Contact: _____ Phone: _____

Previous Dentist: _____ Dental Office: _____

Social Security Number: _____

How did you hear about us?

◯ I live/work in area ◯ I was referred by _____

◯ Social media ◯ Other _____

INSURANCE INFORMATION

◯ No Dental Insurance

◯ Primary Insurance

Name of Insurance Company: _____ State: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group: _____

Name of Employer: _____

Relationship to Insurance holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other _____

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.

_____ _____

Patient Signature Date

DENTAL HISTORY

**Please mark any of the following conditions you may currently have.

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

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

Current Weight: _____(for determining proper dose of medications)

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

HEALTH HISTORY

**Please mark any of the following conditions you may currently have.

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)

_____

Conditions: **Please mark any of the following conditions you may currently have.

YES	NO	AIDS/HIV	YES	NO	Hepatitis type	YES	NO	Stroke
YES	NO	Anemia	YES	NO	Herpes	YES	NO	Swollen Feet
YES	NO	Arthritis, Rheumatism	YES	NO	High blood pressure	YES	NO	Swollen neck glands
YES	NO	Artificial heart valves	YES	NO	Jaundice	YES	NO	Thyroid problems
YES	NO	Artificial joints	YES	NO	Jaw Pain	YES	NO	Tonsillitis
YES	NO	Asthma	YES	NO	Kidney disease	YES	NO	Tuberculosis
YES	NO	Back Problems	YES	NO	Liver disease	YES	NO	Tumor/Growth
YES	NO	Bleeding abnormally	YES	NO	Low Blood pressure	YES	NO	Osteoporosis
YES	NO	Blood transfusion	YES	NO	Mitral Valve Prolapse	YES	NO	COPD
YES	NO	Bruising easily	YES	NO	Nervous problems	YES	NO	Congestive Heart failure
YES	NO	Blood disease	YES	NO	Pacemaker	YES	NO	Chronic Pain
YES	NO	Cancer	YES	NO	Psychiatric Care	YES	NO	Gastric Bypass
YES	NO	Chemical dependency	YES	NO	Radiation Therapy	YES	NO	Bariatric Surgery
YES	NO	Chemotherapy	YES	NO	Respiratory Disease	YES	NO	Restricted Diet
YES	NO	Circulatory Problems	YES	NO	Rheumatic Fever	YES	NO	Gender Reassignment
YES	NO	Congenital heart lesions	YES	NO	Scarlet fever	YES	NO	Glaucoma
YES	NO	Cough	YES	NO	Shortness of breath	YES	NO	Headaches
YES	NO	Diabetes type	YES	NO	Sinus trouble	YES	NO	Heart Problems
YES	NO	Emphysema	YES	NO	Skin rash	YES	NO	Ulcer
YES	NO	Epilepsy	YES	NO	Special Diet	YES	NO	Venereal Disease
YES	NO	Fainting/dizziness	YES	NO	Weight loss	YES	NO	Others, please specify:

_____
_____
_____

Allergies:

YES	NO	Aspirin	YES	NO	Iodine	YES	NO	Amoxicillin/Penicillin
YES	NO	Barbiturates	YES	NO	Latex	YES	NO	Sulfa
YES	NO	Codeine	YES	NO	Local Anesthetic	YES	NO	Epinephrine Sensitivity

Other Allergies not listed: (Please explain in the space provided below)

_____
_____
_____

Are you currently being treated for any other condition? YES NO Please Explain:

_____
_____
_____

Have you been hospitalized (or had surgery) in the last 5 years? YES NO Please Explain:

_____
_____
_____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel and Boniva
Please Circle: NO YES

Have you ever taken any of the group of drugs collectively referred to as "fev-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).
Please Circle: NO YES

Are you currently taking aspirin? Please Circle: NO YES

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

FINANCIAL POLICY

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.**
- **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 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 healthcare needs and welcome any questions 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 ahead of time. 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 or from any such number, without reimbursement from us.

Patient Signature (Parent if Child) **Date**

_____ _____

Capital Smiles
Dr. Erin M. Page D.D.S.

ACKNOWLEDGEMENT OF APPOINTMENT SCHEDULING AND CANCELLATION POLICIES

When you schedule and 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 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 $1000.00 requires a $200.00 deposit, **DUE 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.

- Appointments scheduled with intravenous sedation require a pre-payment of the entire scheduled treatment, **DUE AT THE TIME OF SCHEDULING**. 7 days notice must be given to reschedule. If less than 7 days notice is given because of an unforeseen and unavoidable event, $200.00 of your deposit will be forfeited.

- We ask that 48 hours notice be given to reschedule all other appointments. We understand that last minute and unforeseen events can arise that do not allow for 48 hours notice. A $100 cancellation fee will be charged for any appointment canceled with less that 24 hours notice and is due at the time of the cancellation.

_____ _____

Name of Patient or Responsible Party Signature of Responsible Party

_____

Date

Capital Smiles
Dr. Erin M. Page D.D.S.

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/FACILITIES 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 ☐ I could not communicate with patient ☐ The patient refused to sign
☐ Other: _____
Privacy Officer Signature: _____