Patient Information

Name: ____ ____ Gender M F

Last First Preferred Name/Nickname M.I.

Birth Date: ______________ Social Security #: _____________ Marital Status: ___________

Phone #'s (circle preferred): Home: ____________ Work: ____________ Cell:____________

Appointment Reminders: Email: ______________________ Text: ___________________

Address, City, State, Zip Code: ____

Employer Name: ________________________________ Occupation: ______________

Emergency Contact: ________________ Phone #: ____________ Relationship: _________

Are you satisfied with the appearance of your smile? ____

How did you hear about us? Select one.

- ❑ Internet Search
- ❑ Insurance Company _________________
- ❑ Social Media
- ❑ Noticed while driving
- ❑ Flyer/Postcard in Mail
- ❑ Radio
- ❑ Family/Friend: ____________________
- ❑ Other: ________________________
- ❑ I'm not a new patient

Select the **ONE** answer that best describes what you want from your dental office. **(for ALL patients)**

- ❑ A: A staff that cares about myself and my family.
- ❑ B: An office that is convenient for me to visit.
- ❑ C: A staff who are experts in dental health.
- ❑ D: A doctor who will only do dental work that I need.
- ❑ E: I don't really care as long as my teeth are cared for.

Health Information

Have you ever had any of the following? Please check those that apply:

- ○ ADD/ADHD
- ○ AIDS/HIV+
- ○ Alzheimer's Disease
- ○ Aneurysms
- ○ Arteriosclerosis
- ○ Arthritis
- ○ Artificial joint: _____________
- ○ Asthma
- ○ Breathing Difficulties
- ○ Blood Disorders
- ○ Blood Thinners
- ○ Blood Transfusions
- ○ Cancer: _____________
- ○ Chemotherapy/ Radiation
- ○ Chest Pain
- ○ Chronic Cough
- ○ Cold Sores
- ○ Congenital Heart Defect
- ○ Cortisone Medicine
- ○ Defibrillator
- ○ Depression
- ○ Diabetes
- ○ Dialysis
- ○ Dizziness
- ○ Drug Addiction
- ○ Endometriosis
- ○ Emphysema
- ○ Epilepsy or Seizures
- ○ Excessive Bleeding
- ○ Fainting
- ○ Fibromyalgia
- ○ GERD
- ○ Glaucoma
- ○ Growths/Tumors
- ○ Hay fever
- ○ Head Injuries
- ○ Heart Attack: _____________
- ○ Heart Disease
- ○ Heart Murmur
- ○ Heart Surgery: _____________
- ○ Hepatitis Type: __
- ○ Herpes
- ○ High Blood Pressure
- ○ High Cholesterol
- ○ Hypoglycemia
- ○ Jaundice
- ○ Kidney Disease
- ○ Leukemia
- ○ Liver Disease
- ○ Low Blood Pressure
- ○ Lung Disease
- ○ Mental Disorders
- ○ Mitral Valve Prolapse
- ○ Migraines
- ○ Nervousness
- ○ Organ Transplant
- ○ Pacemaker
- ○ Pain in Jaw Joints
- ○ Pregnant (Current) Due Date: _________
- ○ Psychiatric Care
- ○ Shortness of Breath
- ○ Rheumatic Fever
- ○ Scarlet Fever
- ○ Sinus Problems
- ○ Sleep Apnea
- ○ Stroke: _________
- ○ Swelling of feet/ankles or hands
- ○ Thyroid Disease
- ○ Tobacco Use
- ○ Tuberculosis (TB)
- ○ Ulcers
- ○ Venereal Disease

Have you ever taken Bisphosphonates?
Such as Fosamax, Reclast, Boniva or Actonel
Yes **No**

Have you ever had an Allergic/Reaction to:

- ○ Codeine
- ○ Epinephrine
- ○ Erythromycin
- ○ Latex
- ○ Local Anesthetic
- ○ Penicillin
- ○ Sulfa Drugs
- ○ Other:__________
- ○ **No Allergies**
- ○ **No Medical Concern**

Additional Health Information

Medical problems not listed above: ____

Please list your current medications or provide a list for us to scan into your chart:

____

Have you ever experienced complication following dental treatment? ___________________________

Have you been admitted to a hospital or needed emergency care during the last two years? _______________

Are you currently under the care of a physician & if so, who? ______________________________

Dental Insurance Information

Please complete <u>all</u> fields and provide the front desk with a copy of your insurance card(s):

Main Policy Holder (aka Subscriber) NAME: ______________________________ Relationship Self Spouse Child

List Subscribers Information Below:

Birth Date: _____________________ Social Security #: ______________________ Phone #: _____________________

Mailing Address: ____

Employer Name: ____

Insurance Company / Claims Address: ____

Subscriber ID #: _____________________________________ Group #: ______________________________________

If we do not receive accurate insurance information, we may not be able to verify your insurance on your behalf.

Financial Policy:

Thank you for choosing Williamsburg Dental/Crete Family Dental as your dental care provider; we make every effort to keep our fees reasonable while maintaining the high quality of personalized care our patients expect. In order to assist you with the investment in your dental health, we have outlined your payment options. Please note, accounts not paid within 90 days will be subject to a 16% yearly finance charge.

Non-Insured Patients

For your convenience we accept cash, personal checks, money orders, and credit card payments **at the time of service**. Payment options are available if specific arrangements are made in advance.

Insured Patients

Williamsburg Dental/Crete Family Dental accepts most **traditional dental insurance** plans. We ask that you thoroughly review your policy and be aware of the benefits and limitations as policies can vary greatly. If you are scheduled for restorative treatment you will be asked to pay your estimated co-insurance portion at the time of service. We will then submit to your insurance at no charge to you. We cannot guarantee what your insurance company will pay. After your insurance has processed and paid your claim; an account statement with the remaining balance will be sent to you. Claims not paid by insurance within 90 days are the patient's responsibility.

Payment Options:

- 90 day In-Office Payment Plan (ask for more details).
- 6-12 month interest free plan through Care Credit for balances over $300.00 (ask for more details).

Cancellation Policy:

Our office strives to ensure you are aware of your appointments by sending postcards/emails/texts and finally making reminder phone calls. **Therefore, we ask our patients to reschedule their appointments with at least 24 hours' notice**. Additionally, all patients who miss more than 1 appointment without notice will be charged a rescheduling fee of $25 per person. This amount must be paid in full before the appointment may be rescheduled with the exception of emergency treatment.

Any patient arriving more than 10 minutes late may be asked to reschedule at the team's discretion.

HIPAA Authorization:

I, ____, an individual, hereby authorize Williamsburg Dental LLC/Crete Family Dental, to disclose the following information:

All health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of health care providers, whether past, present or future and any other information which is in any way related to my healthcare. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity that has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization to ANY protected medical information to the persons named in this authorization.

To the following authorized persons:

Name: ____________________ Relationship: _____________________ Telephone #: _____________________

Name: ____________________ Relationship: _____________________ Telephone #: _____________________

Name: ____________________ Relationship: _____________________ Telephone #: _____________________

Name: ____________________ Relationship: _____________________ Telephone #: _____________________

Consent:

To the best of my knowledge, all of the preceding answers and information I have provided are true and correct. If I ever change in my health or insurance coverage; I will inform the doctors at the next appointment without fail.

I authorize the dentist to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the Dentist to make a thorough diagnosis of the patient's dental needs. I also authorize the Dentist to perform any and all forms of necessary treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

I have read the **Financial Policy and Cancellation Policy** and will adhere to this policy by providing Williamsburg Dental/Crete Family Dental with the appropriate notice for rescheduling appointments.

I have been provided with a copy of my **HIPAA Notice of Privacy Practices**; I am aware that my personal or health information will not be released unless it is for medical treatment or to persons specified above or in writing by me.

__________________________________/______________________/____________________________________

Signature of patient, parent or guardian Date Signature of Dentist

Consent to Interview and/or Make and Use Photographs or Recordings, Release or Display of the Information and/or Images.

I hereby give my consent to interviews and/or to have photographs, videos or other images made of myself/my child for the following purposes:

- ✓ Interviews and/or photography for public relations materials created by Williamsburg Dental LLC
- ✓ Interviews and/or photography with the news media
- ✓ Interviews and/or photography for Williamsburg Dental LLC-approved research studies
- ✓ Interviews and/or photography requested by the patient or family for their own use and conducted by a third party
- ✓ Photography to identify the patient in the medical record and/or document patient care
- ✓ Photography for use within Williamsburg Dental LLC for internal staff and student education
- ✓ Photography for use outside of Williamsburg Dental LLC for medical education or teaching
- ✓ Photography to increase the patient's awareness of their progress in therapy
- ✓ Photography to document social and therapeutic recreational activities

This permission is granted on going.

Patient Name (printed): ______________________________ Date: ____________

____ Date: __________________
Signature of Patient, Resident, Parent, Guardian or Attorney in Fact

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OR

Please opt me out of any Photographs or Recordings, Release or Display of the Information and/or Images.