Patient Information

Name: _____ _____ _____ _____ Gender ○M ○F
Last First Preferred Name/Nickname M.I.

Birth Date: _____ Social Security #: _____ Marital Status: _____

Phone #'s (check preferred) ○Home: _____ ○Work: _____ ○ Cell: _____

Appointment Reminders (sent via text & email): Email: _____

Address, City, State, Zip Code: _____

Employer Name: _____ Occupation: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

New Patient Questionnaire (existing patients may skip)

How did you hear about us?

- ○ 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.

- ___ 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.

Are you satisfied with the appearance of your smile?
○Yes ○No, _____

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
- ☐ Dairy
- ☐ Dyes
- ☐ Epinephrine
- ☐ Erythromycin
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Pine Nut
- ☐ 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 complications 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 all 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 60 days will be subject to a 16% yearly finance charge.

Payment Options:

- 60 day In-Office Payment Plan (ask for more details).
- 6-12 month interest free plan through Care Credit for balances over $200.00 (ask for more details).

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.

Cancellation Policy:

Our office strives to ensure you are aware of appointments by sending reminders via email/text and finally making reminder phone calls. **Therefore, we ask our patients to reschedule their appointments with at least 24 hours' notice just as we do our best to reschedule patients (if needed) by giving 24 hours' notice**. Additionally, patients who miss multiple appointments without calling, texting or 24 hours notice may be asked to move to a day-of, call in appointment request method in order to value the patient and doctor's time. Any patient arriving more than 10-15 minutes late may be asked to come back for a second appointment to complete the appointment. Patient's arriving later than that may be asked to reschedule if we are unable to accommodate. In any event, please call our office to communicate if you find yourself running late.

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.

Radiographs: 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.

Financial & Cancellation: 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.

Communication: I am aware that my cellular or landline phone numbers and email addresses provided by myself to this office may be used to contact me, and that this office and service providers may leave messages for me manually and by using automatic systems. If I acquire a new or different cellular, landline or email address, I agree this would remain effective.

Photography: I give my consent to interviews and/or to have photographs, videos or other images made of myself/my child for public relation materials created by Williamsburg Dental, LLC. Materials may include. This permission is granted on going.

- ✓ Interviews and/or photography for public relations materials created by Williamsburg Dental LLC (social media, brochures, website, advertising materials, videos, etc.)
- ✓ Interviews and/or photography with the news media
- ✓ Interviews and/or photography requested by the patient or family for their own use and conducted by a third party
- _ Please opt me out of any Photographs or Recordings, Release or Display of the Information and/or Images.

HIPAA: 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