Vestal Dental Associates

Welcome

Thank you for choosing Vestal Dental Associates for your comprehensive dental care. Our practice is focused on delivering the highest level of personalized care available, while offering an exceptional patient experience. Since our opening in 1955, we have earned the trust and respect of our community with over 100 years of combined service. Our mission is to continue to enhance the lives of others through our commitment to excellence, integrity, and high ethical standards.

Our *New Patient Welcome Packet* serves to gather some information about you in order to create a new patient record. The information provided is strictly confidential and will be used for internal office use and insurance purposes only.

Over the years, many of our patients become like family to us, and as a result the majority of our new patients are referred through word of mouth. We consider this to be the highest form of compliment, and we would like to thank those individuals who referred you to our practice. Even if a patient did not refer you, we would still like to know how you heard about us.

How did you hear about us? _____

Patient History

First Name: _____ Last Name: _____ Middle Initial: _____

Date of Birth: _____/_____/_____ Social Security Number: _____ - _____ - _____ Sex: M / F

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____Extension: _____

Cell Phone: _____ Email Address: _____

Responsible Party: (If someone other than patient. Required for patients under the age of 18)

First Name: _____ Last Name: _____ Middle Initial: _____

Date of Birth: _____/_____/_____ Responsible Party Relationship: Parent / Guardian / Spouse / Other

Address: _____

City: _____ State: _____ Zip Code: _____

Medical Insurance Information:

Name of Policy Holder: _____ Date of Birth: _____/_____/_____

Policy Holder's SSN: _____ - _____ - _____ Relationship to Policy Holder: Self / Spouse / Child / Other

Insurance Carrier: _____ ID #: _____ Group #: _____

Primary Dental Insurance Information:

Name of Policy Holder: _____ Date of Birth: _____/_____/_____

Relationship to Policy Holder: Self / Spouse / Child / Other

Employer: _____ Insurance Carrier: _____

Policy Holder's Social Security Number: _____ - _____ - _____ ID Number: _____

Secondary Dental Insurance Information:

Name of Policy Holder: _____ Date of Birth: _____/_____/_____

Relationship to Policy Holder: Self / Spouse / Child / Other

Employer: _____ Insurance Carrier: _____

Policy Holder's Social Security Number: __ _____ - _____ - _____ ID Number: _____

The information on this form is correct to the best of my knowledge.

_____ Date: _____/_____/_____

Signature of Patient, Designated Person, or Responsible Party

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	(Please list all medications on next page)
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever expereinced excessive bleeding?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Have you ever taken bisphosphonates (Fosamax) or monoclonal antibodies (Prolia)?	Yes No	If yes
Have you ever been treated with radiation to the head and neck region?	Yes No	If yes
Do you need to take antibiotics before dental procedures?	Yes No	If yes
Do you use controlled substances?	Yes No	If yes
Do you use tobacco?	Yes No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Disorders	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Tumors or Growths	Yes No	Congenital Heart Disorder	Yes No
Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No	Convulsions	Yes No
Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No	Yellow Jaundice	Yes No

Have you ever had any serious illness not listed Yes No If yes

Comments:

_____

_____

_____

_____

_____

List any medications you are taking:

Medications	Dosage/Frequency	Prescriber	Reason

Preferred Pharmacy: _____

List any surgeries or hospitalizations you have had:

Date (Year)	Surgery	Surgeon	Reason

Primary Physician's Name: _____ Physician's Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Are you under the care of any other physicians? (If so, please list)

Primary Physician's Name: _____ Physician's Phone: _____

Reason: _____

Primary Physician's Name: _____ Physician's Phone: _____

Reason: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ Date: _____/_____/_____

Signature of Patient, Designated Person, or Responsible Party

Dental History

Reason for today's visit: _____

Date of last visit: _____/_____/_____ Reason for last visit: _____

Do you have any dental problems or discomfort at this time? (If yes, please explain)

_____

Is there anything about the appearance or function of your teeth that you would like to change?

_____

Would you be interested in teeth whitening? _____

Please indicate your level of dental anxiety: None / Slight / Moderate / Severe

Would you be interested in conscious sedation or medication to decrease dental anxiety? _____

Is there anything we can do to make your visit more comfortable? (If yes, please explain)

_____

Do you have bleeding gums? _____

Do you have periodontal disease (gum disease)? _____

Do you have dry mouth or xerostomia? _____

Have you had any previous orthodontic or Invisilign treatment? _____

Do you participate in any sports that require a mouthguard? _____

Do you have frequent headaches or migraines? _____

Do you have any jaw problems or discomfort? _____

Have you had any previous injuries to your face or jaw? _____

Do you clench or grind your teeth? _____

Has anyone ever told you that you snore? _____

Do you suffer from daytime sleepiness? _____

Have you been told that you gasp for air or stop breathing while sleeping? _____

Do you have obstructive sleep apnea? _____

Do you use a CPAP and how often? _____

Notice of Privacy Practices

In compliance with the HIPAA (Health Insurance Portability and Accountability Act) ruling regarding patient privacy of health information, we will be able to speak with only you, the patient, regarding appointments and your health care. However, if you wish to designate another person to schedule appointments and be part of your dental care, please indicate that person below and sign for verification. A copy of this indication will be kept on file until you indicate otherwise. A full copy of our **Notice of Privacy Practices** is available upon request.

_____

Name of Designated person

_____

Printed Patient Name

_____

Patient's Signature

Financial Policy & Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time of payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

_____ Date: _____/_____/_____

Signature of Patient, Designated Person, or Responsible Party

Appointment Policy

In order to best serve our patients, both in quality care and efficient use of time, we take our appointment times very seriously, a considerable amount of preparation is involved in each and every reserved appointment time.

As unexpected demands can sometimes arise, we certainly understand how such circumstances can interfere with your ability to keep your dental appointment. However, we would appreciate **AT LEAST 48 HOURS NOTICE** when possible so that we can use the scheduled time for the benefit of our other patients.

Our team will contact you prior to your scheduled appointment to confirm your reserved time, if a reminder message is left, please respond and contact our office in order to confirm your appointment as soon as possible.

Benefits of Independent Providers

It is our belief that the absolute best care for our patients can be provided in the most cost-effective manner when dental treatment is personalized to the specific needs of each patient, receiving only the treatment that is needed, and completed with highest standards of quality… nothing more, and nothing less.

Therefore, it is our choice to remain independent of the growing number of in-network dental providers. Please understand that dental insurance companies are not motivated by the welfare of their members, but rather their financial bottom line. Both patients and in-network providers can often be pressured by this financially driven mentality, often leading to unnecessary treatment simply because "*insurance pays for it*," or not recommending necessary treatment because "*insurance does not pay for it*." Again, our mission is to provide the highest level of personalized care available, which is possible when we are free to treat our patients in the manner best suited for their needs. We simply cannot accept insurance companies dictating the terms of this care.

Below are some of the benefits of remaining an independent provider and how we can help our patients:

- We will be your personalized insurance advocates, helping you receive the maximum insurance reimbursement to which you are entitled.
- We are able to submit claims to *all* major insurance providers, as opposed to a select few, which can be misleading since many insurance providers claim that our office "does not take your insurance."
- Many in-network dental insurance policies provide out-of-network coverage that is either comparable or exactly the same as their in-network coverage.
- We offer several payment and financing options for any remaining balance that insurance does not cover on your treatment.
- We are always willing to submit prior authorizations to an insurance provider in order to determine exactly what your plan will cover.
- Our practice has no incentive for quantity driven dentistry in order to make up for low insurance reimbursement rates.
- As our focus is on delivering the highest quality treatment, we only recommend treatment that you genuinely need, and we take the time necessary to do it very well.