Williamsburg Dental Works

Williamsburg Dental Works **COMPREHENSIVEDENTISTRY**

Patient Information (Confidential)

Name_______________________________________ _M_ F_
First Middle Last Sex

Address______________________________City___________

State_____Zip________Email________________________

SS#________________________Birthdate__________Age_____

Phone: Home__________________Work_________________

Check Appropriate Box: __ Minor __ Single __ Married
__ Divorced __Widowed __ Separated

If College Student, __ Full time __ Part time

School Name___________________City__________State_____

Patient's or Parent's Employer_________________________

Business Address_____________________________________

City____________________State__________Zip___________

Spouse or Parent's Name_____________________________

Employer___________________Work Phone____________

Emergency Contact_________________________________

Phone____

Dental Insurance Information Only

Name of Insured_______________________________________

Relationship to Patient__________Home Phone____________

Birthdate_________________SS#_______________________

Date Employed___________Employer Name_____________

Union or Local #___________Work Phone________________

Employer's Address____________________________________

City__________________State_______Zip_________________

Insurance Co.________________Tel. #____________________

Ins. Group #________________Policy / ID #______________

Ins. Co. Address_________________________City__________

State_________Zip_________Max. Annual Benefit?_________

How much is your deductible?__________________________

How much have you used this year? ____________________

Do you have any additional insurance ____ Yes ____ No

Responsible Party

Name of Person Responsible For This Account____

Relationship to Patient______________________________Address______________________________

Home Phone_________________________SS#______________________Driver's Liscense #__________________

Birthdate_______________Employer____________________________Work Phone_____________________

Is this person currently a patient in our office? ____ Y _____ N

X____ ______________
Signature of Patient or Parent if Minor Date

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Patient Medical History

Name______________________ Age______ Date__________

	YES	NO
1. Are you in good health?	__	__
2. Have there been any changes in your general health within the past year?	__	__
3. Date of your last physical exam: ____________________		
4. Physician's Name______________________ Address______________________ Phone No. ______________________		
5. Are you now under the care of a physician?	__	__
6. Have you ever been hospitalized for any surgical operation or serious illness? Please explain, ______________________	__	__
7. Are you taking any medicines including nonprescription medicines? If yes, what are you taking______________________ ______________________ ______________________	__	__
8. Bruise easily or abnormal bleeding?	__	__
9. Have you ever required a blood transfusion	__	__
10. Have you had a recent weight loss?	__	__
11. Have you ever taken Fen-Phen or Redux?	__	__
12. Have you ever had biphosphonate drugs for Cancer or Osteoporosis	__	__
13. Do you use tobacco?	__	__
14. Do you or have you used controlled drugs?	__	__
15. Are you wearing contact lenses?	__	__
16. Do you have any disease, condition or problem not listed above that you think I should know about?	__	__
17. Women: Are you pregnant?	__	__
Are you nursing?	__	__
Taking birth control pills	__	__
18. Are you allergic to or have you had serious reactions (other than stomach upset) to:		
Local anesthetics like Novocain	__	__
Penicillin or other antibiotics	__	__
Sulfa drugs	__	__
Barbiturates, sedatives or sleeping pills	__	__
Aspirin or similar NSAIA's	__	__
Iodine or shellfish	__	__
Any metals	__	__
Latex / rubber	__	__
Other (please list) ______________________		
19. Do you have or have you had the following:		
Rheumatic heart disease or rheumatic fever	__	__
Scarlet fever	__	__
Heart defect/murmur, Mitral valve prolapse	__	__
Heart surgery, trouble, attack, or angina	__	__
Chest pain, shortness of breath, pacemaker	__	__
High / low blood pressure	__	__
Hepatitis, jaundice or liver disease		

YES	NO	
__	__	Stroke
__	__	Sinus trouble
__	__	Lung or breathing problems
__	__	Asthma or hay fever
__	__	Hives or skin rash
__	__	Fainting or dizzy spells
__	__	Diabetes
__	__	AIDS or HIV infection
__	__	Thyroid problems
__	__	Allergies
__	__	Arthritis, rheumatism, fibromyalgia
__	__	Joint replacement or any implant
__	__	Stomach ulcer, reflux, IBS, Crohn's
__	__	Kidney trouble
__	__	Tuberculosis, persistent or bloody cough
__	__	Chemotherapy for cancer or leukemia
__	__	Sexually transmitted disease
__	__	Epilepsy or seizures, M.S.
__	__	Anemia or blood disorders
__	__	Glaucoma
__	__	Nervousness or phobias
__	__	Tumors or Cancer
__	__	Mental health care: Diagnosis ____________
__	__	Back problems
__	__	Chemical dependency, addictions
__	__	Cortisone treatment
__	__	Cold sores / fever treatment
__	__	Hypoglycemia
__	__	Eating disorders, bulimia, anorexia
__	__	Chronic pain condition
__	__	Head or neck trauma, whiplash
__	__	Hyperchondriosis
__	__	OTHER (please list)____________________

Patient Dental History

Reason for this visit______________________________

Date of last dental visit________What was done?_______

Previous dentist name / location____________________

Date of last complete series of dental x-rays___________

Circle all that you are concerned about / currently have:

Tooth pain/ache	Sensitivity to:	Hot Cold Sweets
Cavities	Gum disease	Pain to bite
Broken teeth	Broken fillings	Missing teeth
Dark teeth	Ugly teeth	Crooked teeth
Bad breath	Clicking jaw	Fear of dentists
Loose teeth	Spacing	Grinding/clenching
Jaw or face pain	Headaches	Want whiter teeth
Want to save teeth	Poor dentistry	Want gentle dentist
Dream teeth fall out	Recession	Cosmetic dentistry
Snoring / Apnea	Nothing	Bleeding gums

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Dental History

I am changing dentists because: Check any that apply

__ Recently moved into this area from ________________

__ Dr/staff personality ___ Communication problem

__ Inadequate care __ Fee concern __ Insurance

__ Need a second opinion or better option on dental care

__ To find a dentist team who understands my needs

How did you first hear about us? Check any that apply

__ Convenient location (Saw sign on the road)

__ Family member already comes here_______________

__ Referred by a friend _Who?_________________________

__ I received your welcome letter/brochure in the mail

__ I got a postcard mail coupon

__ Yellow Pages

—ZOCDOC.COM __ Google.com

__ Saw your Internet web site at Williamsburgdentalworks.com

__ I dreamed I should come here

__ Social media links: ____ Facebook ___ LinkedIn

__ I prayed for help and here I am __

I have avoided dental care in the past because:

__ Fear of ______________________________________

__ Time commitment __ No perceived need

__ Financial commitment __ Trust factor

If you could change anything about **your smile**, what would you change? ____

Personal Interest Info

Where are you from originally? ______________________

Your occupation and job ___________________________

Schools attended __________________________________

Spouse's name & occupation ________________________

Children's names, ages _____________________________

What's more fun than dental visits? __________________

Are you interested in exploring (check any that apply):

__ Dental wellness (going beyond good health)

__ Ways to reduce or eliminate periodontal surgery

__ Invisalign invisible orthodontic aligners

__ ZOOM office whitening or home whitening

__ The best dental home care systems

__ Why dental infections cause heart & other diseases

__ Sleep apnea or Snoring Treatment Options to CPAP

__ I.V. Sedation and Sleep Dentistry

__ Sedation Dentistry (taking a pill) options

__ Smile Makeover -- Smile Analysis & Design

Authorization & Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to dental examination and any necessary records that are necessary for an accurate diagnosis. I authorize the dentist to use any treatment records, x-rays , models or photos for scientific, teaching or promotional purposes.

X_____________________________________Date_________

Signature of Patient or Parent if Minor

Doctor's Notes:

Pt. Chief concerns

Dr. Chief concerns

Tx Priorities Q I II III IV

Guarded prognosis # ________

Urgency of Tx: Low Med High

Conditions PD 2 3 4 BL G Rec Cav WOD Abfrac Abcess Pulp Phobia MT BC Attrition TMJ Click Pain Ortho Cr Sp XB Cosmetic

Goals SNTG TTLGFGWWAC Wellness Cosmetic Phased Ideal

Options Pro NST 2 3 4 PS Q1 2 3 4 BG FGG CTG Fren Fl Premed Ext RCT PC Apico Biopsy Implant SA CrL 1 2 Q TMJ Ex DxC Tomo K7 T-Scan Equil NG SG NTI Cerec AER Inlay Onlay Cr Br RPD CD OD S OrthoEx Invis RWB Smile Analysis FB DxWax CTemps Veneers C WT Sedation

Doctor's Signature _______________ Date___________

Williamsburg Dental Works

In order to accommodate the needs and requests of our patients, Williamsburg Dental Works does file dental insurance. We are contracted with selected insurance companies. While we are pleased to be able to provide this service to you, it is not possible for our staff to keep track of all the individual requirements of each plan. Every plan has different stipulations regarding access to care and payment for services received. Within the same insurance company, benefits may differ depending upon what type of contract your employer negotiated with that carrier on your behalf.

It is the insured person's responsibility to understand their benefits. We do not wish that your insurance company comes between you and your doctor. You must do your part in understanding the limitations of insurance policies and what your company has purchased for you. Dental benefits differ greatly from medical benefits. In 1959, most dental benefit plans had a yearly maximum cap of $1,000. There has been no significant increase in the yearly maximum cap in 40 years! However, there have been significant increases in your premiums. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.

Many people receive notification from their insurance company that dental fees are "above usual and customary." An insurance company determines their reimbursement level by surveying a geographical area, calculating the average fee, then determines that 80% of the average fee is customary. Included in this survey are discounted dental clinics and managed care facilities, which have severely reduced dental fees that bring down the average. Any doctor in private practice will have fees that insurance companies define as "higher than usual and customary." Our fees reflect the quality you receive.

Many dental benefit plans tell their participants that they will be covered "up to 80% or 100%" but do not clearly specify the plan fee schedule allowance, annual maximum or limitations. It is more realistic to expect dental benefit plans to cover between 25% to 40% of dental services. Remember that the amount a plan reimburses is determined by how much your employer has paid for your dental benefit plan. You will get back only what your employer has put in, less the insurance company's profit margin.

Insurance companies do NOT cover many routine and newer dental services. We bill your insurance as a courtesy. If insurance does not pay within 60 days, Williamsburg Dental Works

reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and YOUR insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office. You will be charged interest at the rate of 1.5% on your account balance. In the event your account is turned over to an outside agency for collections, you will be re-sponsible for all collection fees, costs and such additional sums as the court may adjudge reasonable...such as court costs, attorney fees, service of process in said suite or action.

If you do not inform us of any special requirements in your insurance contract, such as referrals or pre-authorization for treatment, and we subsequently complete services that are not covered, we will have no choice but to bill you directly for those charges. In the event that services are provided and your insurance coverage is not in effect on that day or has a waiting period, or a missing tooth clause, your carrier will probably deny payment for services received. Williamsburg Dental Works can only estimate what your carrier will pay on a specific treatment, if your insurance carrier pays a lesser amount than estimated you will be billed for the difference. It is your responsibility to keep up with the maximum amount of benefits you have used in a calendar year. Please remember that you, the patient, are ultimately responsible for payment on your account.

Our team members will gladly assist you in filling out the necessary forms to maximize your dental benefits and discuss your financial options. Excellent dental care is available with or without dental benefits. We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. We hope you will choose the best that dentistry has to offer.

I have read, and understand, and accept the terms of the about outlined policies for insurance and financial commitments that may incur as a result of treatment at Williamsburg Dental Works.

Signature____

Date____