CAPITOL DENTAL

Capitol Dental Associates, LLC
One Financial Plaza, 19th Floor, Hartford, CT 06103
860-247-5130 | www.capitoldentalassociates.com

INTAKE FORM: PLEASE TRY TO FILL OUT ALL FIELDS TO THE BEST OF YOUR ABILITY	DATE

PATIENT INFORMATION

First Name	Last Name	Middle Initial	Birth Date
Address	City	State	Zipcode
Cell Tel. #	Home Tel. #	Work Tel. #	Best Contact Phone # ☐ Cell ☐ Home ☐ Work
Email Address	Referred By (Name) *(If applicable)*		
Social Security Number	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Other		
Occupation	Employer Name		

EMERGENCY CONTACT INFORMATION

Primary Contact Name	Contact Number	Relationship To Patient
Secondary Contact Name	Contact Number	Relationship To Patient

PRIMARY INSURANCE INFORMATION

Policy Holder Name	Birth Date	Relationship To Patient
Employer Name	Address of Employer	
Insurance Carrier Name	Contact Number	
Patient ID	Group Number	Policy Number

SECONDARY INSURANCE INFORMATION

Policy Holder Name	Birth Date	Relationship To Patient
Employer Name	Address of Employer	
Insurance Carrier Name	Contact Number	
Patient ID	Group Number	Policy Number

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE ***** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT*****

I _____ have received a copy of this office's Notice of Privacy Practices.
Patient Printed Name

Patient Name Printed	Patient Signature	Today's Date

(Patient form continues on reverse side and/or next page)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: ☐ Individual refused to sign ☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement ☐ Other (Please specify below):

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PATIENT MEDICAL HISTORY

Physician Name	Tel. #	Last Exam Date

1. Are you under medical treatment now? ☐ Yes ☐ No

2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ☐ Yes ☐ No
If yes, please explain:

3. Are you taking any medication(s) including non-prescription medicine? ☐ Yes ☐ No
If yes, what are you taking?

4. Have you ever taken Fen-Phen / Redux? ☐ Yes ☐ No 5. Do you use tobacco? ☐ Yes ☐ No

6. Do you use controlled substances? ☐ Yes ☐ No 7. Are you wearing contact lenses? ☐ Yes ☐ No

8. Are you allergic to or have you had any reactions to the following:

Any Metals (e.g. nickel, mercury, etc.)? ☐ Yes ☐ No Aspirin? ☐ Yes ☐ No Barbiturates? ☐ Yes ☐ No Iodine? ☐ Yes ☐ No

Local Anesthetics (e.g. Novocain)? ☐ Yes ☐ No Latex Rubber? ☐ Yes ☐ No Penicillin or any other Antibiotics? ☐ Yes ☐ No

Sulfa Drugs? ☐ Yes ☐ No Sedatives? ☐ Yes ☐ No Other (List):

9. Do you have a persistent cough or throat clearing associated with a known illness (lasting more than 3 weeks)? ☐ Yes ☐ No

10. If you have or have had any of the following, please check the box next to each item

AIDS or HIV Infection ☐ Yes	Emphysema ☐ Yes	Hepatitis / Jaundice ☐ Yes	Recent Weight Loss ☐ Yes
Anemia ☐ Yes	Epilepsy / Convulsions ☐ Yes	High Blood Pressure ☐ Yes	Respiratory Problems ☐ Yes
Angina ☐ Yes	Fainting / Seizures ☐ Yes	Joint Replacement/Implant ☐ Yes	Rheumatic Fever ☐ Yes
Arthritis ☐ Yes	Frequently Tired ☐ Yes	Kidney Diseases ☐ Yes	Sexually Transmitted Disease ☐ Yes
Asthma ☐ Yes	Glaucoma ☐ Yes	Leukemia ☐ Yes	Stomach Trouble / Ulcers ☐ Yes
Cancer ☐ Yes	Hay Fever / Allergies ☐ Yes	Liver Disease ☐ Yes	Stroke ☐ Yes
Cardiac Pacemaker ☐ Yes	Heart Attack ☐ Yes	Low Blood Pressure ☐ Yes	Swollen Ankles ☐ Yes
Chest Pains ☐ Yes	Heart Disease ☐ Yes	Mitral Valve Prolapse ☐ Yes	Thyroid Problems ☐ Yes
Diabetes ☐ Yes	Heart Murmur ☐ Yes	Radiation Therapy ☐ Yes	Tuberculous ☐ Yes
Easily Winded ☐ Yes	Heart Trouble ☐ Yes	Other (List)	

11. Women Only: Are you pregnant or think you may be pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No
Are you taking oral contraceptives? ☐ Yes ☐ No

PATIENT DENTAL HISTORY

Previous Dentist Name	Location	Last Exam Date

1. Do your gums bleed while brushing or flossing? ☐ Yes ☐ No	2. Are your teeth sensitive to hot or cold liquids / foods? ☐ Yes ☐ No
3. Are your teeth sensitive to sweet / sour liquids / foods? ☐ Yes ☐ No	4. Do you feel pain to any of your teeth? ☐ Yes ☐ No
5. Do you have any sores or lumps in or near your mouth? ☐ Yes ☐ No	6. Have you had any head, neck or jaw injuries? ☐ Yes ☐ No
7. Do you have frequent headaches? ☐ Yes ☐ No	8. Do you clench or grind your teeth? ☐ Yes ☐ No
9. Do you bite your lips or cheeks frequently? ☐ Yes ☐ No	10. Have you ever had any difficult extractions in the past? ☐ Yes ☐ No
11. Have you ever had any prolonged bleeding following extractions? ☐ Yes ☐ No	12. Have you had any orthodontic treatment? ☐ Yes ☐ No
13. Do you wear dentures or partials? ☐ Yes ☐ No	If yes, what was the date of placement
14. Do you like your smile? ☐ Yes ☐ No	

15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ☐ Yes ☐ No

16. Have you ever experienced any of the following problems in your jaw?

Clicking ☐ Yes ☐ No Pain (joint, ear, side of face) ☐ Yes ☐ No Difficulty in opening or closing ☐ Yes ☐ No Difficulty in chewing ☐ Yes ☐ No

AUTHORIZATION AND 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 authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (or parent/guardian if minor)_____ Date _____

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OUR FINANCIAL AGREEMENT

Thank you for choosing Capitol Dental Associates LLC as your dental care provider. We are committed to your treatment being as pleasant and stress free as possible. The following is a statement of our Financial Policy, which we require you to read and sign prior to dental treatment. Please understand that payment of your bill is considered part of your treatment.

Regarding Insurance
We accept assignment of insurance benefits. The insurance policy is a contract between you and your insurance company. We are not a party to that contract. All contracts have limits and/or various degrees of co-payment. Please make yourself aware of this specific plan prior to your visit(s). To obtain plan information often you may discuss this with your human resources department, or, call the number listed on your dental insurance card. The treatment recommended by our office is never based on what your insurance will pay; it is based upon our dedication to giving our patients the highest quality dental care. We strive to give patients informed opinions regarding what is best for their oral health. IT IS THE PATIENT'S RESPONSIBILITY TO INFORM THE OFFICE OF ANY INSURANCE CHANGES.

We will do our best to *estimate* what the patient portion will be for future services; this is based upon the information given to us by your insurance company. This estimate amount should NEVER be considered a guarantee of how much your insurance plan will cover nor how much you will be responsible for. Whether your insurance company pays or not, the balance due is ultimately your responsibility. **If your insurance company has not paid your account in full within 45 days, the balance will automatically be transferred to the patient balance and billed directly to the patient**.

Regarding insurance plans where we are participating provider: All co-pays and deductibles are due at the time of any visit. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD, DISCOVER, AMERICAN EXPRESS, AND CARE CREDIT.

Adult Patients
Adult patients are responsible for full payment at time of service.

Minor Patients
The adult accompanying a minor is responsible for full payment. Any divorce decrees stating financial responsibility do not pertain to dental visits. The parent or adult here at the time of treatment is responsible to pay the visit. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized IN WRITING to an approved credit plan or paid by cash or check.

Missed Appointments
Unless canceled AT LEAST 24 HOURS in advance, you will be charged a $50.00 fee for your missed appointment. Reminder calls by our office are a courtesy and should not be relied upon. It is your responsibility to record your appointment dates and times and to show up for your appointments, whether you receive an appointment alert or not. Patients who do not show up for their appointments will be billed regardless if they had received a reminder call or not.

Repeated failed appointments will result in discharge from our care.

You agree that interest at the rate of one and one-half percent per month will be due to this office if any account balance is delinquent more than forty-five days. Although the interest at the rate of one and one-half percent will start to accrue on the forty-sixth day that an account is overdue, the interest itself will not be posted to the account on a continuing basis until the last day of the month in which interest becomes due and payable.

In the event your account is turned over to an attorney for collection, you will be responsible and hereby agree to be responsible for all court costs, State Marshal's fees and reasonable attorney's fees. The court will determine attorney's fees where an attorney on behalf of Capitol Dental LLC brings any legal action.

***PLEASE SIGN AND DATE BOTH STATEMENTS AFTER YOU HAVE COMPLETED READING OUR POLICY.**

I have read in full the financial statement set forth _____ Date _____
Signature of Patient or Responsible Party

I understand and agree to the financial policy set forth _____ Date _____
Signature of Patient or Responsible Party