WELCOME TO ELEVATE DENTAL

In scheduling your first appointment you have taken the first step to achieving optimal dental health. There is one very important aspect of our philosophy, you must "choose" to become healthy. We will guide and coach you by sharing information and allowing you to make an informed decision. The core of our philosophy is being pro-active and preventing dental disease, rather than re-active.

We provide comprehensive care and believe that oral health affects the entire body and overall wellness. Our treatment philosophy is based upon conventional medicine, science and evidence-based practice.

Together we will explore and examine your teeth, gums, joints and create a lifetime treatment plan. Dr. Kristen or Dr. Mike will recommend needed diagnostics, scans and pictures of your teeth. We will review your past dental history, records and x-rays in order to obtain a comprehensive understanding of your personalized needs. With these tools we can determine your present state of dental health and recommend an individualized treatment plan.

In order to maximize your dental benefits, please bring in your insurance information. In order to answer all of your questions, we have put aside an hour and a half for your visit.

MEDICAL HISTORY

Patient Name: ______________________________ Birth Date: __________ Date: ________

Primary Care Physicians Name: ______________________________ Phone #: ______________

Have you been hospitalized or had major operation? Yes ◯ No ◯ If yes____________________

Have you ever had a serious head or neck injury? Yes ◯ No ◯ If yes____________________

Are you taking any medications? Please list with dosages (including vitamins, herbs etc.)

____

____

____

Do you take, or have you taken Phen-Fen or Redux? Yes ◯ No ◯

Have you ever taken Bisphosphonates* Yes ◯ No ◯ *Examples: Fosamax, Boniva, Actonel

Are you on a special diet? Yes ◯ No ◯

Do you use tobacco? Or have a history or smoking? Yes ◯ No ◯

Are you advised to take Pre-med by physician? Yes ◯ No ◯ If yes, what do you take? ____________

Women: Are you...... Pregnant ◯ Nursing ◯ Taking oral contraceptives ◯

ALLERGIES: Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic ◯

Metal ◯ Latex ◯ Sulfa Drugs ◯ Local Anesthetics ◯

Allergies not listed above: ______________________________

Do you use controlled substances or recreational drugs? Yes ◯ No ◯ If yes, ____________________

Do you have, or have you had, any of the following? Check off either Y (yes) or N (no) below.

	Y	N		Y	N		Y	N		Y	N
AIDS/HIV Positive			Cortisone medicine			Hemophilia			Radiation treatment		
Alzheimer's			Diabetes			Hepatitis A			Recent weight loss		
Anaphylaxis			Drug Addition			Hepatitis B or C			Renal dialysis		
Angina			Easily Winded			Herpes (lip or mouth)			Rheumatic fever		
Arthritis/gout			Emphysema			High Blood pressure			Scarlet fever		
Artificial heart valve			Epilepsy or seizures			High Cholesterol			Shingles		
Artificial joint			Excessive Bleeding			Hives or Rash			Sickle cell disease		
Asthma			Excessive Thirst			Hypoglycemia			Sinus trouble		
Blood disease			Fainting spells/dizzy			Irregular heartbeat			Spina bifida		
Blood transfusion			Frequent Cough			Kidney problems			Stomach/intestinal disease		
Breathing Problems			Frequent Diarrhea			Leukemia			Stroke		
Bruise Easily			Frequent Headaches			Liver disease			Swelling of limbs		
Cancer			Genital Herpes			Low blood pressure			Thyroid disease		
Chemotherapy			Glaucoma			Lung disease			Tonsillitis		
Chest Pains			Hay Fever			Mitral valve prolapse			Tuberculosis		
Cold Sores			Heart attack/failure			Osteoporosis			Tumors or growths		
Congenital heart disorder			Heart Murmur			Pain in jaw joint			Ulcers		
Convulsions			Heart pacemaker			Parathyroid disease			Veneral disease		
Yellow Jaundice			Sleep Apnea			Psychiatric care			Blood thinner		
Human Papilloma Virus (HPV)			ADD/ADHD			Use of C-PAP			Autism/Asperger syndrome		
Multiple Sclerosis											

Med. Hx Continued....

Have you ever had any serious illness not listed above? Yes ◯ No ◯ If yes ______________________

Have you been told you needed to have a sleep study? Yes ◯ No ◯ If yes ______________________

If yes to cancer, what type of cancer, when? ______________________

If yes to chemo/radiation, if so when? How many Grays (Gy) have you been exposed to?

Comments:

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

Signature of Patient, Parent or Guardian

X ______________________ Date ______________

DENTAL UPDATE QUESTIONNAIRE

Name ________________________________ Date:__________________

Are you experiencing any discomfort? _______ If yes explain____

Does dental treatment make you nervous? ____

Date of last dental visit ___________ Date of last dental cleaning _____________

Have you ever been treated for gum disease?____

How often do you brush? _________ Type of tooth brush: manual ◯ electric ◯ Do you floss? ________

Do you wear a mouthguard made by a dentist at night? ____

Please check off if you have or ever had any of the following:

MOUTH	**TEETH**
◯ Bleeding sore gums	◯ Loose teeth
◯ Unpleasant taste/bad breath	◯ Sensitivity to hot
◯ Burning tongue/lips	◯ Sensitivity to cold
◯ Frequent blisters	◯ Sensitivity to sweets
◯ Swelling/lumps	◯ Sensitivity to biting
◯ Clicking or popping jaw	◯ Food catching between teeth
◯ Difficulty opening/closing	◯ clenching or grinding, if so when.... ◯ daytime ◯ nighttime
◯ Braces or Invisalign	◯ shifting in bite

Is there anything you would like to change about your smile? ____

What things are most important to you about your dental health? ________________________________

Have you lost any teeth? _________ if so, have they been replaced? _____ if not, why? _________________

Are you unhappy with the replacements? ______________ if so why? ____________________________

Would you be interested in learning more about replacements? ________________________________

Do you have any difficulty getting numb? _______ if yes explain ________________________________

Have you experienced any problems or complications with previous dental treatment? If yes, please explain.

____

Please circle your answer to the following 7 statements:

1.) My mouth is a.) very comfortable b.) moderately comfortable c.) uncomfortable

2a) I think the appearance of my mouth is excellent
2b) I am satisfied with the appearance of my mouth
2c) I am disappointed with the appearance of my mouth

3a) I have set goals for my oral health with a previous dentist
3b) I want to set goals concerning my dental health

4a) I have put dentistry for myself and family high on priority list completed
4b) I have put dentistry for myself and my family low on priority list
4c) I have dentistry on my list, but its hard to find

5a) I will do anything to keep my natural teeth
5b) I want to keep my teeth, but have a budget of time and money I am willing to spend
5c) I expect I will lose most/all of my teeth like my parents did

6a) I have always done the best recommended for my dental health
6b) I have not done what dentists have recommended to me
6c) I rarely go and don't care about having any dental work

7.) I think my present state of dental health is a.) excellent b.) good c.) poor

What are some questions about dentistry that you have never had adequately answered? ____________________

____

elevate dental

369 Heineberg Drive, Colchester, VT 05446
T: 802-658-4873
Fax: 802-863-5400
Info@elevatedentalvt.com

RECORDS RELEASE TO ELEVATE DENTAL

I, (print full legal name) ______________________________, on (date)_________ give permission for my previous dentist (please fill in information below) to release all pertinent records to Elevate Dental:

Name of Practice:

____

Address:

____

Phone number: ___________________________Fax: __________________________

Email: ____

Patient Name: ____

Patient Signature: ________________________________ Date: _______________

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Financial, Insurance and Appointment Policy

Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from responsibility for the payment of all charges.

Insurance Assignment and Release

I certify that I and/or my dependent(s) have insurance coverage with company above and assign directly to Elevate Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all the charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions. Liscio dental may use my healthcare information and may disclose such information to the above insurance company or companies and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Commitment to Appointments

For the benefit of our patients, we work with one patient at a time. (We reserve a time for each patient separately.) When you make an appointment, it is a bond of trust that we will be here to serve you and you will in turn, be here at the scheduled time. Please be present for your scheduled appointments. In this way, we can serve your dental needs. We ask that on the rare occasion you need to cancel or change appointment you give us a 48-hour notice or 2 business days. If your appointment is broken or canceled without a 48-hour notice, a $75 fee may be assessed to your account for any hygiene related appointment, and $125 for a doctor related appointment.

Please sign below to indicate you understand and agree to all of the policies and statements above.

Patient Signature ____

Print Name ________________________________ Date ____________

Kristen Gibilisco DMD FAGD FICOI & Michael Gibilisco DMD
369 Heineberg Dr., Colchester, VT 05446
802.658.4873 // elevatedentalvt.com

elevate dental

Notice of Privacy Practices

Consent for Use and Disclosure of Health Information

Patient Information

First Name ____ MI ______

Last Name ____

Address ____

Phone Number ____

Email ____

SS# ____

Signing below, I have thoroughly read Elevate Dental's Notice of Privacy Practices and understand how my medical information may be used and disclosed and also how I am able to get access to my medical information.

Patient Signature: ____________________________________ Date ______________

Please initial each statement below:

_______ I understand and acknowledge my rights as detailed in the Notice of Privacy Practices Presented here.

_______ I understand and consent to my medical information being used as described here.

_______ I understand the terms and authorize the practice to disclose my medical information to those parties as mentioned here.

Kristen Gibilisco DMD FAGD FICOI & Michael Gibilisco DMD
369 Heineberg Dr., Colchester, VT 05446
802.658.4873 // elevatedentalvt.com

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Authorization to Charge Credit/Debit Card

To authorize a one-time or recurring charge to your credit card for treatment services rendered, please complete and sign this form. We adhere to the highest standards for account data protection.

Patient Billing Information

Patient Name: ____

If patient under 18 years of age, Guardian's Name: ______________________________________

Billing Address: ____

City________________________________ State: ___________________ ZIP: ________________

Phone: ____________________________

E-mail: ______________________________________

Credit Card Type: ___Visa ___MasterCard ___American Express ___Discover

Cardholder Name (on credit card): ____

Credit Card #: ________________________________ Expiration: ___________ Security Code: ________

I hereby authorize Elevate Dental to charge my credit card above in the amount of $45 for on any occasion in which I fail any Hygiene related appointment at Elevate Dental, and $125 for any Doctor related appointment. This is a one-time charge authorization. I am not authorizing Elevate Dental to set up my account for recurring billing. I understand all cancellations regarding my account must be in writing. I guarantee that I am the legal cardholder for this credit card account and that I am legally authorized to use it.

Signature of Cardholder: __________________________________ Date: _________________