Robert P. Vignali, DDS, PLLC
29 Colvin Avenue
Albany, New York 12206
518-459-7993

Dear

Welcome to our dental practice. Our dedicated and experienced team has been providing quality and comfortable care to the residents of the Capital District for over twenty-five years.

We offer an innovative “dental wellness” program that begins with an in depth one-on-one conversation with each patient at their initial visit. Our complete examinations are based on the most advanced technology resulting in individual and personal prevention and treatment programs.

Whether you are visiting for routine dental health care, restorative or cosmetic treatments, our “patients come first” philosophy centers on you. We use the most comfortable and advanced techniques available. We strive to not only provide quality care to each of our patients, but to also ensure that our treatments are clearly explained and understood.

Please complete the patient information forms enclosed and return them to our office. This will save you time when you come in for your initial appointment. As soon as we receive and review your information, we will call you to schedule your first visit with Dr. Vignali.

Thank you for choosing us and I look forward to meeting you soon.

Caring for your dental health,

Dr. Robert Vignali

COLVIN AVENUE DENTAL

Caring for your dental health

REGISTRATION

PATIENT NAME ______________________________ DATE ____ /_____ /_____

LAST ***FIRST*** ***INITIAL***

(CIRCLE): Mr Mrs Ms Dr Fr Sr Jr Bro I prefer to be called ______________

If child, Parents Name ______________________________

Residence Address ______________________________

City ______________ State ______________

Zip code ______________

Mailing address ***(IF DIFFERENT)*** ______________

City ______________ State ______________

Zip code ______________

Phone: Home ______________ Cell ______________

Work ______________ ext.__________

Best number to reach you during the day? ______________

Email Address ______________________________

Employer ______________________________

Position / Occupation ______________________________

Business Address ______________________________

Date of Birth ________ / __________ / _________

(CIRCLE) Male or Female

Social Security Number ______________________________

Marital Status ***(CIRCLE)*** :

Married Single Divorced Widowed Long Term Partner

Spouse Name / Parent Name ______________________________

Spouse Employer ______________________________

Spouse Phone Number ______________________________

Person Responsible for this account ______________________________

Billing address ***(IF DIFFERENT)*** ______________

City ______________ State ______________

Zip code ______________

Full Time Student? Yes No (School) ______________

How and / or from whom did you learn about us? ______________

____

In the event of an emergency, is there someone we should contact? ____

Name ______________ Relation ______________

Phone Number ______________

DENTAL INSURANCE 1st COVERAGE

Subscriber ______________________________

Date of Birth ______________________________

Relationship to patient ______________________________

Employer Name ______________________________

Name of Insurance Co. ______________________________

____

Address ______________________________

____

Telephone ______________________________

Program or Policy # ______________________________

Subscriber SSN or ID # ______________________________

Group # ______________________________

DENTAL INSURANCE 2nd COVERAGE

Subscriber ______________________________

Date of Birth _____ / ___________ / _______

Relationship to patient ______________________________

Employer Name ______________________________

Name of Insurance Co. ______________________________

____

Address ______________________________

____

Telephone ______________________________

Program or Policy # ______________________________

Subscriber SSN or ID # ______________________________

Group # ______________________________

DENTAL RECORDS, *RADIOGRAPHS*

Part of a complete and thorough initial oral exam is a Full Mouth Series (FMX) of radiographs (X-rays). Our digital radiography provides accurate imaging quickly and safely, with far less radiation than traditional imaging methods. A FMX consists of 14-22 radiographs showing teeth and the entire root and 4 Bitewing or check-up radiographs which show the crowns of upper and lower teeth only.

If you have had a FMX in the past three years, you are welcome to have your previous dentist mail us a copy. If they are of diagnostic quality we will reference those and perform just 4 Bitewing radiographs at your first visit.

PLEASE CHOOSE ONE THE OF THE FOLLOWING:

☐ I will have a Full Mouth Series of radiographs taken at my initial visit. I am ready to schedule.

☐ I am asking my previous dentist to mail a current FMX (taken in the past 3 years) to your office. I would like to schedule after these are received.

FINANCIAL POLICY

We are committed to providing exceptional dental care to all our patients. In order to achieve this goal, we need your assistance and your understanding of our payment policy. Patients are responsible for payment of services rendered. We offer several options for payment including cash, check, credit or debit and as well as our in-office financing through CareCredit and CitiHealth payment plans.

If you have dental insurance we will be happy to prepare and submit the claims for you. We can accept assignment of benefits and estimate your deductible and any portion not covered by your insurance. This amount is due at time services are rendered. Please remember that your dental insurance is an agreement between you, your employer and the insurance company. Insurance assists with payment of services but does not relieve one of any financial obligations.

If you have any questions regarding the information above, do not hesitate to call us….we are here to help! We will never allow the limitations of your benefits to compromise the quality of your care.

CONSENT AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

I have read and understand the questions asked on these forms and certify that the information I have given is correct. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform of any changes to my medical status.

I authorize Dr. Robert Vignali, DDS, PLLC to release any information including the diagnosis and the records of any treatment or examination rendered to me, to third party payors and/or health practitioners. I authorize Robert P. Vignali, DDS, PLLC to perform any necessary dental services that I may need during diagnosis and treatment.

I understand the financial policy and also assign all insurance benefits, if applicable, to Robert P. Vignali, DDS, PLLC.

______________________________ PATIENT/RESPONSIBLE PARTY SIGNATURE

_____ / _____ / _____ DATE

DENTAL HISTORY

1. Why have you come to the dentist today?

____

____

2. Are you aware of any problems?

____

____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

3. Are you happy with your smile and teeth?........ YES / NO
4. Would you like whiter teeth? .... YES / NO
5. Do your gums bleed or hurt when brushing or flossing? .... YES / NO
6. Have you ever been instructed on the correct method of brushing your teeth? .... YES / NO
7. Are any of your teeth sensitive to: (circle) Hot? Cold? Sweets? Pressure? .... YES / NO
8. Have you lost any teeth or have any teeth been removed?........ YES / NO

   IF YES, PLEASE EXPLAIN ______________________________

9. Have missing teeth been replaced? .... YES / NO
10. Are you happy with the replacements? .... YES / NO
11. Do you clench or grind your teeth during the night or day? .... YES / NO
12. Have you experienced any pain or soreness in the muscles of your face or around your ear? .... YES / NO
13. Have you had clicking, popping, pain or difficulty while opening and closing your jaws or chewing? .... YES / NO
14. Do you have frequent headaches, earaches, or neck pains? .... YES / NO
15. Do you currently wear or have an occlusal appliance (niteguard)? .... YES / NO
16. Have you ever had any problems or complications with previous dental treatment? .... YES / NO

    IF YES, EXPLAIN: ______________________________

    ____

17. Have you been treated by a periodontist? .... YES / NO
18. Do you feel your breath is offensive at times? .... YES / NO
19. Do you feel your mouth is always dry? .... YES / NO
19. Does food get caught in your teeth? .... YES / NO
20. Have you had any unpleasant experiences or is there anything about dentistry that you strongly dislike? .... YES / NO

    PLEASE EXPLAIN: ______________________________

    ____

21. Would you like to speak to Dr. Vignali privately concerning any problems? .... YES / NO

PREVIOUS DENTIST ______________________________ DATE OF LAST VISIT _____ /______ /______

PATIENT NAME ______________________________ DATE ____ /_____ /_____

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Caring for your dental health

MEDICAL HISTORY

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

1. Are you under a physician's care?... YES / NO
2. Are you taking any medications? .... YES / NO
   IF YES, PLEASE LIST IN THE SPACE TO THE RIGHT.
3. Do you need to take antibiotic premedication before dental treatment?.. YES / NO
4. Do you have any artificial joints/prosthesis?............................ YES / NO
5. Have you ever been treated for heart disease?......................... YES / NO
6. Do you have a pacemaker, heart valve replacement, or been diagnosed with mitral valve prolapse?........................ YES / NO
7. Have you ever had rheumatic fever?..................................... YES / NO
8. Are you allergic to any medication or substances?................... YES / NO
   IF YES, PLEASE LIST IN THE SPACE TO THE RIGHT.
9. Do you have any other allergies?... YES / NO
10. Do you have any problems with penicillin, antibiotics, anesthetics or other medications?.......................... YES / NO
11. Are you sensitive to any metals or latex?................................. YES / NO
12. Are you pregnant?... YES / NO
13. Do you use any birth control medications?................................ YES / NO
14. Have you ever had any of the following?................................. YES / NO
    PLEASE CIRCLE ANY THAT APPLY

Heart Murmur	Arthritis/Rheumatism	AIDS or HIV Positive
Low Blood Pressure	Visual Impairment	Epilepsy
High Blood Pressure	Asthma	Blood Diseases
Respiratory Disease	Hepatitis Type_________	Radiation Treatments
Diabetes	Kidney Disease	Psychiatric Treatment
Hearing Loss	Stomach/Intestinal Disease	Seizures

15. Have you ever bled excessively after being cut/injured? .... YES / NO
16. Are you diabetic?... YES / NO
17. Do you smoke, chew, or use any other forms of tobacco?......... YES / NO
18. Do you habitually use controlled substances?........................... YES / NO
19. Do you have any disease condition or problem not listed? .... YES / NO
    IF SO, PLEASE EXPLAIN ____

PATIENT NAME ____ DATE ____ /_____ /_____

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SMILE EVALUATION CHECKLIST

PATIENT NAME ____ DATE ____ /_____ /_____

To aid in our diagnosis and treatment of your esthetic concerns, please take a moment and answer the following questions. ***PLEASE CIRCLE YOUR ANSWER.***

Do you dislike the color of your teeth? .... YES / NO

Do you have spaces between your teeth that bother you? .... YES / NO

Do you have chips or uneven edges on your teeth? .... YES / NO

Do you feel your teeth are too long or too short? .... YES / NO

Do you have dark fillings that show when you smile? .... YES / NO

Are your teeth crowded or crooked? .... YES / NO

Do you have existing crowns or dental work that you consider “ugly”? .... YES / NO

Are you self-conscious of your teeth and/or smile? .... YES / NO

Has anyone (family member, friend, etc.) ever suggested that you should have something done with your teeth or smile? .... YES / NO

Do you avoid smiling when you have your picture taken? .... YES / NO

Would you like to improve your existing smile? .... YES / NO

Do you wish you had a “new smile”? .... YES / NO

What concerns do you have regarding dental treatment to improve your smile? ....

- ☐ Fear of treatment
- ☐ Time to complete treatment
- ☐ Financial considerations
- ☐ Distance to office
- ☐ Unaware of treatments available
- ☐ Embarrassment
- ☐ Other