Elisa S. Liberto, DMD
COMPLETE DENTISTRY

Patient Dental & Medical Health History Form

To our patients: Please know that we may ask follow-up questions to make sure we have all the information we need in order to treat you.

Patient Information	
Last Name:	First Name:
Home Phone:	Cell Phone:
Email address:	
Mailing address:	City:
State:	Zip code:
Date of birth:	Gender:
Who referred you to our practice?	
Emergency Contact Information	
First & Last Name:	
Phone number:	
Relationship to patient:	
Patient Insurance Information	
Primary Dental Insurance:	
Insurance member #:	
Are you the main policy holder? ☐ YES ☐ NO If no, who is the policy holder? _____ What is their DOB? _____	
Do you have a secondary Insurance? ☐ YES ☐ NO	
If yes, please provide secondary insurance carrier: _____ Member ID# _____ Policy Holder Name and DOB:	
Dental History & Symptoms	
What is the reason for your visit today?	
Are you currently experiencing any pain/discomfort? ☐ YES ☐ NO	
When was your last dental exam?	
When was the last time you had dental x-rays taken?	
Please mark an "X" in the box ONLY if it applies to you.	
Is it hard to open your mouth? ☐ YES ☐ NO Does it hurt to chew, bite or swallow? ☐ YES ☐ NO Do your gums bleed when you brush/floss? ☐ YES ☐ NO	

Have you ever had gum treatments (scaling, root planning) ☐ YES ☐ NO
Do you have any sores or growths in your mouth? ☐ YES ☐ NO
Do you clench or grind your teeth? ☐ YES ☐ NO
Does your jaw click, pop or hurt? ☐ YES ☐ NO
Do you have earaches or neck pain? ☐ YES ☐ NO
Does dental treatment make you nervous? ☐ YES ☐ NO
Have you ever experienced any of these sleep-related breathing disorders?
☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep

☐ Have had a serious injury to your head or mouth?
If yes, what happened and when?

☐ Have had problems with dental treatment in the past
If yes, what happened?

☐ Have had a reaction to, or problem with anesthesia
If yes, what happened?

☐ Am unhappy with smile
☐ Color ☐ Shape ☐ Position
☐ Other

Medications & Other Products / Substances

Please use an "X" to mark your answers to the following questions.

Are you taking any blood thinners?..... ☐ YES ☐ NO
If yes, what are you taking? _____

Are you taking any medication to treat osteoporosis or Paget's disease? ..... ☐ YES ☐ NO
If yes, what are you taking? _____

Are you taking, or scheduled to take an IV medication to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ..... ☐ YES ☐ NO
If yes, what are you taking? _____
If yes, how long have you been taking it? _____

Are you taking any hormonal replacements? ..... ☐ YES ☐ NO

Do you use any form of tobacco or nicotine products (cigarettes, cigars, chew, vapes)? ..... ☐ YES ☐ NO

How many alcoholic beverages do you have per week? _____

Do you use controlled substances, including marijuana, for either medical or recreational reasons? .... ☐ YES ☐ NO
If yes, what substance? _____
If yes, how often? _____

Do you take any other prescriptions or over-the-counter medicines, vitamins, herbs or supplements?... ☐ YES ☐ NO

If yes, please list them here: _____

Women Only: Are you:

Taking birth control pills? ..... ☐ YES ☐ NO
Pregnant? If yes, number of weeks: _____
Nursing? If yes, number of weeks: _____

Allergies **Please use an "X" to mark your answers to the following questions.**

Are you allergic to or have you had an allergic reaction to:

Aspirin	☐ YES	☐ NO
Barbiturates, sedatives or sleeping pills	☐ YES	☐ NO
Codeine or other narcotics	☐ YES	☐ NO
Hay fever / Seasonal allergies	☐ YES	☐ NO
Iodine	☐ YES	☐ NO
Latex	☐ YES	☐ NO
Local anesthetics	☐ YES	☐ NO
Metals	☐ YES	☐ NO
Penicillin or other antibiotics	☐ YES	☐ NO

Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasalazine (Azulfidine), erythromycin-sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix) ☐ YES ☐ NO

Other ☐ YES ☐ NO

Medical & Surgical History

Date of last physical exam:	What is your normal blood pressure?
Primary Care's Name:	Phone #

Are you in good health?	☐ YES	☐ NO
Are you currently being seen by a physician?	☐ YES	☐ NO
Has a previous dentist recommended you take antibiotics after dental work?	☐ YES	☐ NO
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐ YES	☐ NO
Have you had any type of joint replacement surgery?	☐ YES	☐ NO
Have you had a heart valve replacement or heart surgery?	☐ YES	☐ NO
Have you had an organ or bone marrow/stem cell replacement?	☐ YES	☐ NO
Have you traveled internationally in the last 30 days?	☐ YES	☐ NO
Have you had a fever in the last 72 hours?	☐ YES	☐ NO

Medical History Specific **Please use an "X" to mark your answers to the following questions.**

Do you have, or have you been diagnosed with any of the following conditions?

Heart (Cardiac) Health

Pacemaker / Implanted defibrillator	☐ YES	☐ NO
Artificial (prosthetic) heart valve	☐ YES	☐ NO
Previous infective endocarditis	☐ YES	☐ NO
Congenital heart disease	☐ YES	☐ NO
Unrepaired, cyanotic CHD	☐ YES	☐ NO
Repaired in the last 6 months	☐ YES	☐ NO
Repaired CHD with residual defects	☐ YES	☐ NO
Arteriosclerosis	☐ YES	☐ NO
Coronary artery disease	☐ YES	☐ NO
Congestive heart failure	☐ YES	☐ NO
Damaged heart valves	☐ YES	☐ NO
Heart Attack	☐ YES	☐ NO
Heart murmur / rhythm disorder	☐ YES	☐ NO
Rheumatic heart disease	☐ YES	☐ NO
Stroke	☐ YES	☐ NO

Respiratory Health

Asthma (COPD)	☐ YES	☐ NO
Bronchitis	☐ YES	☐ NO

Cancer ☐ YES ☐ NO

Type:
Date of diagnosis:
Chemotherapy
Radiation treatment

Blood Health

Anemia	☐ YES	☐ NO
Blood transfusion	☐ YES	☐ NO
If yes, date:		
Hemophilia	☐ YES	☐ NO

Neurological Health

Anxiety	☐ YES	☐ NO
Depression	☐ YES	☐ NO
Epilepsy	☐ YES	☐ NO
Mental health disorder	☐ YES	☐ NO
Neurological disorder	☐ YES	☐ NO
PTSD	☐ YES	☐ NO

Emphysema	☐ YES	☐ NO	Traumatic brain injury	☐ YES	☐ NO
Sinus trouble	☐ YES	☐ NO	Concussion	☐ YES	☐ NO
Tuberculosis	☐ YES	☐ NO			
			Other		
Autoimmune Disease			Arthritis	☐ YES	☐ NO
AIDS or HIV infection	☐ YES	☐ NO	Chronic pain	☐ YES	☐ NO
Lupus	☐ YES	☐ NO	Diabetes	☐ YES	☐ NO
			Eating disorder	☐ YES	☐ NO
			Frequent infections	☐ YES	☐ NO
Digestive Health			Hepatitis or liver disease	☐ YES	☐ NO
Gastrointestinal disease	☐ YES	☐ NO	Immune deficiency	☐ YES	☐ NO
G.E. reflux / persistent heartburn	☐ YES	☐ NO	Kidney problems	☐ YES	☐ NO
Stomach ulcers	☐ YES	☐ NO	Malnutrition	☐ YES	☐ NO
			Osteoporosis	☐ YES	☐ NO
Eye Health			Rheumatoid arthritis	☐ YES	☐ NO
Glaucoma	☐ YES	☐ NO	Sexually transmitted disease	☐ YES	☐ NO
			Thyroid problems	☐ YES	☐ NO

Do you have any disease, condition or problem that is not listed here?

Medical Symptoms / General

Please use an "X" to mark your answers to the following questions.

In the past 30 days, have you:

Had chest pain or tightness?	☐ YES	☐ NO
Coughed up blood?	☐ YES	☐ NO
Had a cough that lasted longer than 3 weeks?	☐ YES	☐ NO
Been exposed to anyone with tuberculosis?	☐ YES	☐ NO
Had a rapid or irregular heart beat?	☐ YES	☐ NO
Fainted?	☐ YES	☐ NO
Noticed a change in your vision?	☐ YES	☐ NO
Found it hard to catch your breath?	☐ YES	☐ NO

NOTE: It is important for both the doctor and patient talk honestly about the patient's health before treatment.
I have answered the above questions completely, accurately and to the best of my ability.

Patient / Guardian Signature: _____

Date: _____

For Completion By Dentist

Comments: _____

Office Use Only: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

Reviewed by:

Date: _____

Elisa S. Liberto, DMD
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Financial Policy

Thank you for choosing Elisa Liberto, DMD! It is our primary goal to deliver the best and most comprehensive care available. We strongly believe in making the cost of your care as clear and manageable as possible for each of our patients.

As a courtesy to each patient, we verify your insurance benefits prior to your visit to ensure that you receive your maximum allowable benefit. It is important to note that benefits given by the insurance company are not a guarantee and claims could be processed differently than quoted. You are ultimately responsible for all charges.

Payment is due at the time of your service unless other arrangements have been made prior to treatment. Payments may be made using Check, Cash, Credit and Care Credit. Any checks that are returned to our office from your financial institution are subject to a $25 returned check fee.

Appointment Policy

In order to maintain a healthy Doctor-patient relationship and to provide the best dental care possible, it is essential for you to keep your scheduled appointments. We require a 48 hour notice when cancelling or rescheduling an appointment. If less than 48 hours is given or if you fail to make it to a scheduled appointment, there will be a $100 fee. Appointment cancellations should be made during our regular business hours by speaking to our front office staff.

We do understand that things come up, however we ask for a courtesy call to let us know that your appointment no longer works for you. Exceptions will be made for emergency situations. We care a great deal about you as our patient and thank you for your consideration of our schedules as well as doing your part to achieve and maintain optimum oral health!

Please indicate your understanding and acceptance of our financial and appointment policies by signing below.

Patient Name:	Date:
Patient/Guardian Signature:	Date:
Witness Signature:	Date:

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67 Jefferson Boulevard• Warwick, Rhode Island 02888
(401) 781-8696 • team@libertodmd.com • rihealthysmiles.com

CREDIT CARD AUTHORIZATION FORM

Patient Name:_____ Date of Birth: _____

Credit Card Information	
Cardholder Name (as it appears on card):	
Card Type: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover	
Card Number:	CVV Code:
Expiration Date:	Billing Zip Code:

Authorization Agreement

I authorize Dr. Elisa Liberto, DMD to securely store my credit card information and charge it for the following:

- Payment for services rendered.
- Balances remaining after insurance has processed a claim.
- Missed appointment fees or late cancellation fees as outlined in the office policy.

I understand that:

- My card information will be stored securely and in compliance with PCI DSS standards.
- This authorization remains valid until I provide written notice to revoke it.
- It is my responsibility to inform the office of any changes to my credit card information.

Cardholder Signature: _____ Date: _____

Employee Signature: _____ Date: _____

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General Consent for Treatment And Local Anesthesia

Patient Name:	Patient DOB:

I give consent for myself / my child to receive dental treatment as deemed necessary by the providers at Elisa Liberto, DMD. The procedures include, but are not limited to; examinations, oral prophylaxes (cleanings), fluoride treatment, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bleeding, discomfort, prolonged numbness/tingling, nausea, vomiting, allergic reactions, rapid or irregular heartbeat or jaw muscle spasms and cramps.

I understand that I must inform the dentist of any prescription or over-the-counter medications I am taking as these may interact with local anesthetics. I understand my dentist's recommendation of local anesthetic for all for all procedures that require adequate pain control and the risks of local anesthesia.

Depending on the procedures, minor to moderate sensitivity of the teeth and soreness of the gums in the area treated are completely normal. If you have any questions or concerns, do not hesitate to contact our office.

PLEASE ASK THE DENTIST IF YOU HAVE ANY QUESTIONS REGARDING THIS CONSENT FORM. DO NOT SIGN IF YOU HAVE NOT HAD YOUR QUESTIONS ANSWERED.

I hereby acknowledge that I have read this document and have discussed all questions or concerns that I may have.

_____ _____

Patient or Guardian Signature Date

_____ _____

Witness Signature Date

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PHOTO RELEASE FORM

We are asking your permission to use selected before and after photos for educational purposes, communication and advertising purposes. We will not use full face photographs or disclose your identity in any way.

I hereby grant permission to Elisa S. Liberto, DMD to use photographs and/or videos of me taken at the office of Elisa S. Liberto in publications, news releases, online, social media and in other communications related to the mission of the dental office.

Patient Name: _____

Guardian Name (if applicable): _____

Patient/Guardian signature: _____

Thank you!

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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You may refuse to sign this acknowledgement **

Patient Name:	Date:

I have received (or have been offered) a copy of this office's Notice of Privacy Practices. By signing this form, you are giving this office your consent to use and disclose health information about you for treatment, payment, and health care operation purposes.

_____

Patient / Guardian Signature:

_____

Witness Signature:

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

☐ Communications barriers prohibited obtaining the acknowledgments

☐ An emergency situation prevented us from obtaining acknowledgements

☐ Other (Please Specify):

_____

_____

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Smile Evaluation

Patient Name:	Date:

Do you like the appearance of your teeth; your smile? ☐ YES ☐ NO
If not, please explain: _____
_____

Are your teeth all in alignment (straight)? ☐ YES ☐ NO
If not, please explain: _____
_____

Do you have spaces that you don't like? ☐ YES ☐ NO
If not, please explain: _____
_____

Do you like the color of your teeth? ☐ YES ☐ NO
If not, please explain: _____
_____

Do you like the shape of your teeth? ☐ YES ☐ NO
If not, please explain: _____
_____

Are your teeth chipped, protruding or hidden? ☐ YES ☐ NO
If yes, please explain: _____
_____

Are your teeth wearing on the biting surfaces? ☐ YES ☐ NO
If yes, please explain: _____
_____

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Are there old fillings or dental work you don't like? ☐ YES ☐ NO
If yes, please explain: _____
_____

Would you consider braces to correct your esthetic issues? ☐ YES ☐ NO

Are you happy with the appearance of your gum tissue? ☐ YES ☐ NO

What would you like to change the most in the appearance of your teeth?

_____

How would you like your teeth to look?

_____
_____