Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us because we will be happy to help.

Patient Information

Date________________________

Name_________________________Cell Phone__________________ Home Phone___________________
Address___________________________________ City___________________ State____ Zip _________
Email address ____________________________Social Security ___________________Birthdate_______
Age______ Check Appropriate Box: Child Single Married Divorced Separated
Patient's Employer ______________________________________ Occupation ______________________
Business Address___________________________City_________________Work Phone ______________
Spouse's Name ____________________Employer______________________Cell Phone______________
If Student, Name of School / College______________________________ Full Time Part Time
Person to Contact in Case of Emergency_________________________________Phone ________________
Whom May We Thank for Referring You____

Responsible Party

Name of Person Responsible for this Account ____
Relationship to Patient______________Birthdate________________Social Security #_________________
Address (if different from above)_______________________City _______________State____Zip________
Name of Employer____Work Phone ________________
Is this Person Currently a Patient in our Office? Yes No

Insurance Information

Name of Insured____Relationship to Patient______________
Birthdate__________________ Social Security #_____________________Work Phone_______________
Name of Employer_____________________________ Insurance Company_________________________
PLEASE ALLOW US TO COPY YOUR INSURANCE CARD

Additional Insurance

Is Patient Covered by Additional Insurance? YES NO
Name of Insured____Relationship to Patient______________
Birthday__________________Social Security #______________________Work Phone_______________
Name of Employer_____________________________Insurance Company _________________________

Patient Medical History

Physician___________________________Office Phone_______________Date of Last Exam____________

1. Are you under medical treatment now? Yes No If yes, describe____________________________
2. Have you been hospitialized for any operation or serious illness within the last 5 years? Yes No
If yes, please describe____
3. Are you taking any medication(s) including non-prescription medicine? Yes No If yes, please list____
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4. Are you allergic to or have you had any reactions to any medication? Yes No If so, please describe____
Are you allergic to or have you had any reactions to latex rubber? Yes No
5. Do you have allergies to other substances? (e.g. foods, pollens, animals) Yes No
If so, please list____
6. When you walk up stairs or take a walk, do you ever have to stop because of a pain in your chest, shortness of breath, or because you are very tired? Yes No
7. Do you snore? Yes No
8. Women only: Are you taking oral contraceptives? Yes No Are you pregnant or think you may be pregnant? Yes No, Are you nursing? Yes No
9. Do you have or have you had any of the following?

	Yes	No		Yes	No
Heart Attack			Breathing Problems		
Heart Surgery			Sinus Infections		
Heart Disease			Hay Fever		
Chest Pain			Diabetes		
Mitral Valve Prolapse			Kidney Disease		
Heart Murmur			Thyroid Disease		
Rheumatic Fever			Liver Disease		
High Blood Pressure			Hepatitis		
Low Blood Pressure			AIDS or HIV Infection		
Swollen Ankles			Venereal Disease		
Anemia			Herpes		
Bruise Easily			Stomach Problems or Ulcers		
Stroke			Cancer		
Blood Transfusion			Chemotherapy		
Fainting Episodes			Radiation Therapy		
Epilepsy or Seizures			Psychiatric Care		
Asthma			Glaucoma		
Emphysema			Arthritis		
Tuberculosis			Joint Replacement		

Authorization and Release

I have read the above information and it is accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. If there is any change in my medical status, I will inform the dentist. I authorize the dentist to release any information including the diagnosis and the records of treatment rendered to me or my child to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (or parent if minor)____________________________Date___________

SMILE ANALYSIS FORM

Please consider each statement carefully and circle YES or NO. Dr. Platt and members of the dental team will discuss your responses with you in confidence.

	Statement		
1.	I am concerned about the appearance of my teeth or my smile.	YES	NO
2.	I am concerned about the whiteness/lack of whiteness of one or more of my teeth.	YES	NO
3.	I am concerned about the position or angle of one or more of my teeth.	YES	NO
4.	I am concerned about the shape of one or more of my teeth.	YES	NO
5.	In social situations, I am sometimes embarrassed by my teeth or my smile.	YES	NO
6.	There are some things about my upper front teeth that I would like to change.	YES	NO
7.	There are some things about my lower front teeth that I would like to change.	YES	NO
8.	I have old fillings or previous dental treatment that is no longer satisfactory to me.	YES	NO
9.	My bite is sometimes uncomfortable when chewing or biting.	YES	NO
10.	I am interested in learning more about cosmetic dentistry.	YES	NO

Have you ever had a bad experience in the dental office? YES NO If yes, please explain.

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Let us know if there is anything that we can do to make your dental visits more pleasurable or comfortable. Please use the space below to indicate any other problems, concerns, or questions. We will make every effort to listen attentively to your concerns so that we can present you with the best treatment options. Thank you.