PATIENT INFORMATION FORM

DATE ____________________

LAST NAME __________________ FIRST NAME ___________________ M.I.___
HOME ADDRESS ____
CITY ______________________ STATE __________________ ZIP ________________
HOME PHONE (   ) ______________ WORK (   ) _____________ CELL (   ) ________
AGE ____ DOB _________ MARITAL STATUS ____ SPOUSES NAME ___________
OCCUPATION __________________ E-MAIL ADDRESS __________________________
REFERRED BY ____

PRIMARY INSURANCE INFORMATION

SUBSCRIBER NAME ____
ADDRESS (IF DIFFERENT FROM PATIENT) _________________________________
RELATION TO PATIENT ___________ SS# ____________________ DOB __________
EMPLOYER NAME & ADDRESS ____
____

GROUP # __________________________

SECONDARY INSURANCE INFORMATION

SUBSCRIBER NAME ____
ADDRESS ____
RELATION TO PATIENT _____________ SS# ___________________ DOB _________
EMPLOYER NAME & ADDRESS ____
____

GROUP # ___________________________

AUTHORIZATION

I hereby authorize my dentist, Dr. Scott Schaffer, and my dentist's staff to act on my behalf in connection with a claim for any dental benefit or an appeal of any adverse dental benefit determination that I personally could pursue in my own name. In furtherance of this authorization, I also authorize my dentist to seek advice from and to enlist the assistance of the NJ Dental Assoc., its legal counsel and other pertinent employees, and without obtaining a business association agreement, to convey to them any information, including protected health information, pertinent to the claim or the appeal. This authorization is continuing and will remain in effect until revoked by me in writing.

I understand & authorize Dr. Schaffer, his associates and staff to take diagnostic materials needed to make a final diagnosis of treatment. These materials may include intra-oral pictures, digital radiographs, models, photographs and slides. This material may be used for lectures, articles and/or publications.

I hereby acknowledge that I have been provided with a copy of the Notice of Privacy Practices.

Please print name ______________________________________

Signature ____

(PLEASE TURN OVER)

ODO YOU LIKE THE APPEARANCE OF YOUR TEETH? YES { } NO { }

WHAT WOULD YOU LIKE TO CHANGE MOST ABOUT THE APPEARANCE OF YOUR TEETH?____________________

____

____

MEDICAL HISTORY

PHYSICIAN:____________________ ADDRESS____________________
CITY____________________ ZIP__________ PHONE____________________

DO YOU NOW HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO
HEART DISEASE	{ }	{ }	RADIATION THERAPY	{ }	{ }
HIGH BLOOD PRESSURE	( )	{ }	LIVER DISEASE	{ }	{ }
BLOOD DISEASE	{ }	{ }	KIDNEY DISEASE	{ }	{ }
RHEUMATIC FEVER	{ }	{ }	HEPATITIS	{ }	{ }
HEART MURMER	{ }	{ }	ASTHMA	{ }	{ }
DIABETES	{ }	{ }	TUBERCULOSIS	{ }	{ }
STROKE	{ }	{ }	ALLERGY TO:		
EPILEPSY (SEIZURES)	{ }	{ }	PENICILLIN	{ }	{ }
ARTHRITIS	{ }	{ }	OTHER ANTIBIOTICS	{ }	{ }
VD	{ }	{ }	OTHER DRUGS/MEDS	{ }	{ }
ARTIFICIAL HEART VALVE	{ }	{ }	OTHER ANESTHETIC	{ }	{ }
ARTIFICIAL JOINTS	{ }	{ }	AIDS, HIV OR ARC	{ }	{ }

DO YOU SMOKE? { } { } IF YES, HOW MUCH?__________
HAVE YOU BEEN HOSPITALIZED WITHIN THE LAST TWO YEARS? YES { } NO { }
IF YES, PLEASE EXPLAIN____________________

____

DO YOU TAKE ANY DRUGS OR MEDICATIONS? (INCLUDING BIRTH CONTROL PILLS)
YES { } NO { }
IF YES, PLEASE LIST____________________
ARE YOU PREGNANT? YES { } NO { }
DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE?
YES { } NO { }
IF YES, PLEASE EXPLAIN____________________

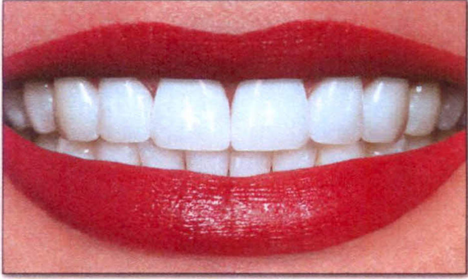
____

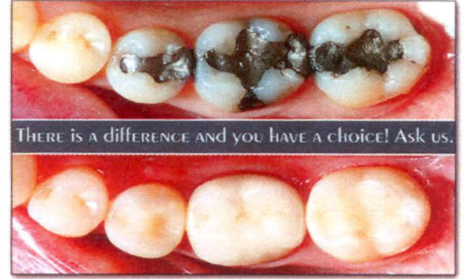
I CERTIFY THAT ALL THE INFORMATION STATED ABOVE IS TRUE.
SIGNATURE: ____________________ DATE:__________
PATIENT, PARENT OR GUARDIAN

DENTIST'S SIGNATURE: ____________________ DATE:__________

DATE	COMMENTS	SIGNATURE
______	____________________	__________
______	____________________	__________
______	____________________	__________

Valley Road Dental Excellence
Smile Evaluation





Name____________________________________ Date__________________________________

1) Do you like the way your teeth look? Yes (   ) No (   )
Explain: ____

2) Would you like for your teeth to be whiter? Yes (   ) No (   )
Explain: ____

3) Would you like your teeth to be straighter? Yes (   ) No (   )
Explain: ____

4) Do you have spaces between your teeth that you would like closed? Yes (   ) No (   )
If so, where? ____

5) Do you like the shape of your teeth? Yes (   ) No (   )
Explain: ____

6) Do you have missing teeth that you would like to replace? Yes (   ) No (   )
Explain: ____

7) Do you have old silver fillings that you would like to replace with tooth-colored fillings? Yes (   ) No (   )
Explain: ____

8) If you could change anything about your smile, what would you change?
Explain: ____

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