Old-fashioned service meets new dental technology

drjaredplitt

333 41st street suite 706
miami beach, fl 33140
305.534.2525
www.drplitt.com

New Patient History Form

Thank you for choosing our dental office. We take great pride in offering state-of-the-art professional care while providing good old-fashioned service.

We have attempted to make it as easy as possible to enter your information on the next several pages. Wherever there is a checkbox or drop-down list simply select the appropriate choice.

The electronic form should be completed, saved, and then emailed back to us.

Alternatively, the form can be printed out and brought with you to your appointment.

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Basic Information

Last Name _____ First Name _____

Preferred Name / Nickname _____ Date of Birth /_ _/_

Email _____ Street Address _____

City _____ State _FL_ Zip _____

Social Security # _____ Marital Status _
(only required if you have dental insurance)

Phone # Home _____ Cell _____ Work _____

How may we contact you for future appointments? Phone ☐ Email ☐ Text Message ☐
(select all that apply)

Emergency Contact: _____ #: _____ Relationship _____

Referral Source

We value our reputation and are extremely appreciative when someone makes the effort to share the word about our service & quality of care. Who may we thank for referring you to our office?

☐ Patient Name: _____ ☐ Yelp ☐ Google ☐ Angie's List

☐ Web Search (keywords used?): _____ ☐ Other _____

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Medical Information

Do you have or have you ever been treated for any of the following:

- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Condition
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV or AIDS
- ☐ Kidney Disease
- ☐ Prosthetic Valve
- ☐ Tuberculosis

Have you ever had an allergic reaction to any of the following:

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetic
- ☐ Jewelry
- ☐ Latex
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Other: _____

Have you ever had:

- ☐ A reaction to dental anesthetic?
- ☐ Prolonged bleeding after surgery?
- ☐ Other dental complication: _____

If you are a woman, are you:

- ☐ taking birth control pills?
- ☐ nursing?
- ☐ pregnant? months

Please select any medications you are taking:

- ☐ Aspirin
- ☐ Cholesterol Medication
- ☐ Coumadin
- ☐ Antidepressants
- ☐ Blood Pressure Medication
- ☐ Pain Medication
- ☐ Other: _____

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Dental Information

How often do you brush? _____ How often do you floss? _____

Is a specific dental problem bothering you today?	Y ☐	N ☐
If so, please describe it: _____		
Do you smoke or chew tobacco?	Y ☐	N ☐
Do you think you have tooth decay?	Y ☐	N ☐
Do you think you have gum disease?	Y ☐	N ☐
Are you aware of your gums bleeding?	Y ☐	N ☐
Have you lost any teeth?	Y ☐	N ☐
Do you have any loose teeth?	Y ☐	N ☐
Are your teeth sensitive to hot or cold?	Y ☐	N ☐
Do you hear clicking or popping in your jaw sometimes?	Y ☐	N ☐
Do you have discomfort in the joint of your jaw sometimes?	Y ☐	N ☐
Are you aware of any tooth grinding or clenching habits?	Y ☐	N ☐
Do you wear a removable full or partial denture?	Y ☐	N ☐
Have you ever had braces?	Y ☐	N ☐
If yes, do you still wear a retainer?	Y ☐	N ☐
Are you happy with the color of your teeth?	Y ☐	N ☐
Is there anything you would like to change about your smile?	Y ☐	N ☐

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Dental Information

Have you had a serious or difficult problem with any previous dental work? Y ☐ N ☐

Have you ever had any unfavorable dental experiences? Y ☐ N ☐

Why did you leave your previous dentist?

(select all that apply)

Office Cleanliness ☐ Long Wait Time ☐ Unfriendly or Unhelpful Staff ☐

Dentist's Personality ☐ Dentist's Performance ☐ Other ☐ _____

How can we accommodate you better during your dental visit? _____

_____

We are proud to offer a wide variety of services to enhance and keep your smile beautiful. Please check any of the services you would like our friendly staff to discuss with you during your visit.

Tooth Whitening ☐ Cancer Screening ☐ Crowns / Bridges ☐

Veneers ☐ Bonding ☐ Partials / Dentures ☐

Clear Braces ☐ Dental Implants ☐ Night / Sports Guards ☐

Other ☐ _____

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Photographic Consent Form

Part of your treatment may include photographs of the face and teeth.

We may want to use these photographs taken of you for treatment planning, consultation, educational, and promotional purposes.

Please read the optional choices below and select one:

☐ I agree to allow Dr. Plitt to use my **recognizable** photographic likeness for consultation, educational, and promotional purposes.

Or

☐ I agree to allow Dr. Plitt to use my **closeup** photos for consultation, educational, and promotional purposes. I understand that the images will be made in such a way that I will **NOT** be recognized.

Signature

I certify that the information I have provided is true and accurate to the best of my knowledge.

Signature: _____ Today's Date: _____

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Financial Policy

We accept cash, checks, and all major credit and debit cards.

Payment in full is due at the time of service unless one of the following financial arrangements are chosen prior to treatment:

Pre-Payment Discount Option: We offer a 5% accounting discount for all patients who choose to pre-pay for treatment at least 1 week in advance (applies to balances over $500).

Multiple Appointment Payment Option: We offer a multiple payment option for treatment plans with more than 1 visit. We ask that you pay one-half at the first appointment and the balance over the remaining appointments.

Credit Card Payment Plan: We offer a Credit Card Payment Plan with a signed agreement form. Patients can divide their balance into pre-established payments. The credit card on file will be charged the agreed fees on a scheduled timetable.

Checks
There is a $40 returned check fee. Balances due from returned checks, not paid within 30 days, will be prosecuted fully according to Florida statute 832.05.

Delinquent Balances
In the rare event that your account becomes past due and is referred to an outside collection agency or attorney, you will be responsible for all collection costs, reasonable attorney fees, and court fees incurred by this office.

Insurance
Insurance companies rarely cover 100% of all procedures. We are able to check and verify most benefits before treatment begins however, insurance payments and exclusions change constantly and although we use the most up-to-date information, it is ONLY AN ESTIMATE.

All insurance copays and deductibles must be paid at the time of service. The patient is responsible for any charges that insurance does not cover.

Please indicate that you understand and accept our office's financial policies by signing below. This will also cover any dependent children who are patients of this practice.

Signature: _____ Today's Date: _____