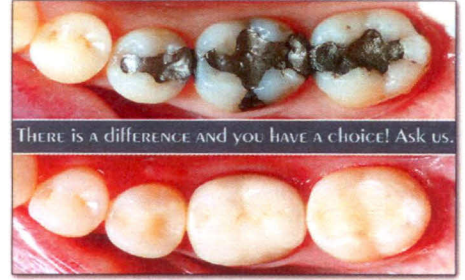


Valley Road Dental Excellence Smile Evaluation



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: _____

**Dr. Scott Schaffer 77 Valley Rd. Clark, NJ 07066
(732) 382-2715**

DO 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 MURMUR	{ }	{ }	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
_____	_____	_____
_____	_____	_____
_____	_____	_____

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)