William R. Platt, D.D.S.

Patient Information and Health History and Office Policy

Please complete in full the Patient Information, Spouse/Responsible Party and Medical History parts of this form. If patient is a minor, please provide information regarding responsible party.

PATIENT INFORMATION Email: _____

❑ Mr. ❑ Dr. ❑ Mrs. ❑ Miss ❑ Ms. Name _____
Last First M.I.

Address: _____
Street Apt..# City State Zip

Birthdate: _____ Cell#: _____ Work#: _____ Home# _____

Place of Employment: _____
Co. Name Address City State

Dental Ins. Co.: _____ Group No.: _____

Social Security No.: _____ Drivers License No: _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

❑ Mr. ❑ Dr. ❑ Mrs. ❑ Miss ❑ Ms. Name _____
Last First M.I.

Address: _____
Street Apt..# City State Zip

Birthdate: _____ Telephone No.: _____
Mo. Day Yr. Home Work

Place of Employment: _____
Co. Name Address City State

Dental Ins. Co.: _____ Group No.: _____

Social Security No.: _____ Drivers License No.: _____

Has any member of your family ever been treated in our office? ❑ Yes ❑ No

Whom may we thank for referring you to our office? _____

DENTAL HISTORY

Primary reason for this appointment: _____

❑ Yes ❑ No Do you have a specific problem? Describe _____

❑ Yes ❑ No Do you feel nervous about having dental treatment?

❑ Yes ❑ No Do you brux or grind your teeth, or have popping or clicking?

❑ Yes ❑ No Have you been told you have "gum disease?"

❑ Yes ❑ No Do you feel you might need (Nitrous Oxide) inhalation gas to calm you during treatment?

❑ Yes ❑ No Are you interested in whitening your teeth?

❑ Yes ❑ No Would you be interested in discussing a snore prevention device with the Doctor?

MEDICAL HISTORY

Medical doctor's name: _____

Are you under a doctor's care now? Why?: _____ ❑ Yes ❑ No

Have you been hospitalized or received a blood transfusion? When?: _____ ❑ Yes ❑ No

Are you taking any medications, pills, or drugs? What?: _____ ❑ Yes ❑ No

Are you allergic to any medications or substance? What?: _____ ❑ Yes ❑ No

(over)

MEDICAL HISTORY (cont.)
Please CIRCLE if you have had any of the following:

Heart Trouble	Stroke	Liver Disease	Epilepsy or Seizures
High Blood Pressure	Diabetes	Hepatitis A (infec.)	Nervousness
Low Blood Pressure	Excessive Thirst	Hepatitis B (serum)	Alzheimer's Disease
Heart Murmur	Artificial Joints/Hips	Yellow Jaundice	Hypoglycemia
Rheumatic Fever	Kidney Trouble	Recent Weight Loss	Psychiatric Care
Congenital Heart Lesion	Ulcers	Cancer	Drug Addiction
Artificial Heart Valve	Allergies	Thyroid Disease	Blood Transfusion
Heart Pacemaker	Scarlet Fever	Parathyroid Disease	Hemophilia
Heart Surgery	Asthma	X-ray or Cobalt Treatment	AIDS (HIV)
Blood Disease	Hay Fever	Chemotherapy/Radiation	Venereal Disease
Anemia	Sinus Trouble	Arthritis/Gout	Cold Sores
Chest Pain	Emphysema	Rheumatism	Fever Blisters
Shortness of Breath	Frequent Cough	Pain in Jaw Joints	Herpes
Swelling of Feet/Ankles/ Hands	Lung Disease	Cortisone Medicine	Bruise Easily
Fainting or Dizziness	Tuberculosis	Glaucoma	Sickle Cell Anemia

Have you ever had any other serious illness not circled above?: _____ ❑ Yes ❑ No

Please describe in detail: _____

Do you wish to talk to the doctor privately about any problem: _____ ❑ Yes ❑ No

Person to contact outside of immediate family in case of emergency: _____

Method of Payment: (We do accept *Visa* and *Master-Card* if you need credit)

❑ Payment in full at each appointment. (This applies to all private patients and also those patients assigned on a list to our office).

❑ Insurance benefits assigned to our office. In order for our office to accept benefits the patient must bring in a completely signed insurance form for every visit. Payment must be made for your deductible and the portion not covered by your insurance at each appointment.

❑ If you need additional credit, please ask for an application for our Dental Charge Credit Card to see if you qualify. Any other credit and/or delayed billing must be approved by us solely at our discretion.

FINANCE CHARGE: If I do not pay the entire New Balance within 60 days a FINANCE CHARGE will be added to the account for the current monthly billing period. The FINANCE CHARGE will be a period rate of 1.5% per month which is an ANNUAL PERCENTAGE RATE of 18% applied to the last month's balance in the case of default of payment. I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

BROKEN APPOINTMENT AND CANCELLATIONS WITH LESS THAN ONE WORKING DAY'S NOTICE: In order to use our time most efficiently and accommodate all our patients' needs, we try to stay as close to our schedule as possible. When patients do not come in for scheduled appointments or cancel with less than 24 business hours notice, our time is wasted. When proper notice is given we can adjust our schedule by getting patients in sooner and accommodating any dental emergency patients that need to be seen immediately. We do charge for broken appointments and last minute cancellations, so please be sure to cancel or change your appointment with adequate notice. Charges will be determined by either your dental plan or by our private fee schedule.

To avoid a charge you must notify us (or leave a message on our phone machine) at least 24 hours minimum before the appointment cancellation or change. Calling on a weekend or any major legal holiday does not count as an adequate business day notice. Please only schedule appointments when you know you will be able to keep them.

TERMINATION OF DENTIST-PATIENT RELATIONSHIP: Should you be considerably late for your appointment (s), it may be necessary to reschedule you and you may be liable for a failed appointment charge. Should you feel you don't fit into our practice, you are free to end our relationship at any time without notice and upon written notice, we will transfer copies (but not originals) of any records at slight or no charge as specified by Nevada laws. Upon demand, all past due fees unpaid are due within ten days or your account may be placed for collection.

I (we) agree a) should my account be turned to collection; or b) should I be habitually late for appointments; or c) constantly change or miss them; or d) should I be a substance abuser; or e) should I fail to follow up with necessary care and or advice, that these actions willfully constitute my termination of dental treatment for myself and my immediate family and I (we) will seek any and all care elsewhere immediately. I (we) shall no longer ask for nor expect any future dentistry or treatments whatsoever should any of the above conditions apply.

I authorize payment directly to dental office of group insurance benefits payable to me if dental office agrees to accept assignment of benefits. I authorize this dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I agree to pay for any broken appointments or those changed without sufficient notification. The information on this page and the medical history are correct to the best of my knowledge.

Patient Signature: _____ Date _____