New Patient Platform

A Note From the Doctor:

In this day and age, when health care provider's relationships with their patients have become impersonal, I'd like to take a few minutes to let you that this is not the experience of a new patient at my practice.

You see, dentistry has undergone immense changes. Technologically we're way ahead, but not all of the changes are good. To me it feels as if a lot of the caring has gone out of the profession (as is so often in many professions). I became a dentist to proved patients with safe, pain-free, quality dental care. But I also became a dentist because I cared about the person behind the smile.

I think you'll find that we are different from other dental offices in some significant ways. Here's what it means for you.

> On your first visit you'll be doing most of the talking. After all, who knows you and your concerns better than you? In fact, I don't believe doctors can make a proper diagnosis without getting their patient's input. I believe in treating people, not just teeth.
>
> You'll also find us taking more time to provide gentle care than you're used to. This is a primary concern of mine-no one likes discomfort. We always provide you with the latest in anesthetic and painless techniques. This can take more time, but we believe you're worth it.
>
> Also, I want you to know that I give the best dentistry can offer. I am meticulous in my approach to prevention. My continuing education and 28+ years experience ensure you're getting the foremost in material and technique.
>
> Basically, I will treat you as I would my own family, because that is what caring is all about.

My staff and I feel honored that you've selected us over everyone else.

Yours in the Interest of Optimal Oral Health,

Mark A. Poitras, DDS

Here are some tips to help prepare you for your first visit:

Get a good night's sleep. Giving the brain ample time to rest will soothe nerves and dispel any anxiety you might be experiencing about your first visit.

Choose a dentist you can trust. Dr. Poitras believes in maintaining an open line of communication with his patients. This can actually bolster patient confidence and eventually breed long-term doctor-patient relationships.

Avoid sugary or caffeinated beverages. These tasty drinks not only perk you up energy-wise, but will increase anxiety as well.

Verify your appointment. Confirm your appointment at least 48 hours in advance.

Organize your information. Be ready to provide a comprehensive medical history, including itemizing any medications or supplements you are taking. And don't forget to disclose any hospitalizations, surgeries, or allergies. Sometimes patients don't understand why we spend so much time going over medical history forms when we're working on teeth. Ever heard the mouth is the gateway to the body?

Confide your dental anxiety. Don't be afraid to confide your fears to us. We have several options to make even your first visit less stressful.

Come early. Avoid rushing and give yourself plenty of time to feel comfortable and relaxed in our dental office atmosphere.

Pressed for time? New patients can speed up their check-in process by completing their patient forms prior to your visit with Dr. Poitras. Please feel free to call our office if you have any questions about the paperwork.

Be truthful with your answers. As your partner in oral health, Dr. Poitras needs to have a transparent and comprehensive perspective of your dental health status, so the right treatment plan can be recommended for you.

Once you're seated in the chair, Dr. Poitras and his team will perform a comprehensive examination to check for signs of diseases and potential problems. Expect the following evaluation:

- Complete screening of the head and neck (oral cancer screening)
- Examination of the gums and supporting periodontal structures

- Soft and hard tissue evaluation
- Clinical examination of the teeth
- Radiographs (x-rays)
- Oral hygiene instruction
- Bite or occlusion assessment (including clenching and/or grinding)
- As well as possible assessment for signs and symptoms of:
    - Obstructive sleep apnea
    - Snoring and sleep disturbances
    - Acid-reflux/GERD
    - Caries (cavity) risk assessment, including pH and dietary habits

If you have any questions, or are interested in becoming part of our dental family, give us a call! And don't forget to check out the different promotions we offer to new patients. We look forward to meeting you!

Wondering when your child's first dental visit should be? You're not alone.

Those early months and years for your child are filled with firsts! And most parents don't realize that a dental visit should be among them. The best time to schedule your child's 1st dental check-up is when their 1st tooth erupts, or around their 1st birthday.

We know what you're thinking, your child only has two teeth! They can't possibly have cavities yet?

Unfortunately, baby teeth are more porous, which is why they tend to be more susceptible to decay then adult teeth. This is why early intervention is critical to help ensure those tiny teeth stay healthy. And cavities aren't the only thing we're looking at. Dr. Poitras is trained to identify any immediate or potential issues with the growth and development of your child's jaw and soft palate. Studies show that patients who've had early, positive, dental experiences as children grow up to be better adult dental patients. So start young, because practice makes perfect!

Here are ways that you can help us make your child's 1st dental experience a positive one:

- **Come visit us**. Prior to your child's 1st visit, we recommend bringing your child by the office for him or her to meet the staff and take a look around. This empowers the child, and breeds confidence and familiarity with Dr. Poitras and the team before they ever step foot in a treatment room.
- **Select an appointment time where your child will be alert and rested.** Ensuring your child is feeling at their best will help visits go smoothly. We suggest that the last meal be about 2 hours prior to their visit (if possible).
- **You have the greatest influential role on your child's dental health**. With most of us having children ourselves, we know that trusting your child with others can be difficult, especially if you're new to us as well. However, children often perceive their parent's anxiety which in turn makes them more fearful. Oftentimes, children are more relaxed with us when their parents aren't in the room. Not only does it show your child that you have confidence in us to take exceptional care of them, but it also helps us build a relationship with your child one-on-one. We do adhere to an *"Open Door Policy",* which allows you to interact with your child during certain aspects of the visit. Otherwise we will politely ask that you wait in our relaxing waiting room. Bring a book; enjoy yourself! You are more than welcome to frequently stop by the operatory and check on your child discreetly. If you need to be closer for your own peace of mind, we'll even set up a chair for you outside the treatment doorway so you're just an earshot away. Remember, as you become more confident, so will your child.
- **Prepare your child for the visit by talking about the dentist**. Be cautious about which words you use, and reassure your child that the dentist is a friend who wants to help keep their teeth healthy. When possible avoid stories and perceptions of negative dental experiences. This will allow your child to form their own opinions about their new dental home. There are numerous online resources and YouTube videos (*Luca Lashes and His First Visit to the Dentist* or *Caillou at the Dentist*), and even more books on the subject ("Emily's First Visit to the Dentist" or "The Bernstein Bears Visit the Dentist").
- **Make a list of questions and concerns you may have.**

- **Give your child some control of the visit or day.** Maybe let them choose which outfit they'll wear to the office, or allow them pick a favorite toy to bring along.

Creating positive experiences **before**, **during**, and **after** their dental visits has a huge impact your child's long-term dental health and the success of future visits. If you have any questions about your child's 1st visit, our *"Open Door Policy"*, or you need a Dental Health Certificate for Kindergarten, please feel free to give us a call.

PLEASE PRINT

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S LEGAL NAME LAST, FIRST MI	DATE OF BIRTH	SEX	SOCIAL SECURITY #

PREFER TO BE CALLED	HOME PHONE #	CELL PHONE #

PATIENT'S ADDRESS STREET APT# CITY STATE ZIP	E-MAIL

MARITAL STATUS ☐ S ☐ M ☐ W ☐ D ☐ UNDER AGE 18	PATIENT'S / GUARDIAN'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET APT# CITY STATE ZIP	WORK PHONE #

SPOUSE'S NAME LAST, FIRST MI	SPOUSE'S EMPLOYER	OCCUPATION

SPOUSE'S WORK ADDRESS STREET APT# CITY STATE ZIP	WORK PHONE #

OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE	WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?

EMERGENCY CONTACT INFORMATION

PERSON WE MAY CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME	RELATIONSHIP

HOME PHONE #	WORK PHONE #	CELL PHONE #

REQUEST FOR CONFIDENTIAL COMMUNICATION

AS MY DENTAL CARE PROVIDER, YOU MAY DO THE FOLLOWING WITH MY PERMISSION:

	YES	NO
Contact me at home	☐	☐
Contact me via cell phone	☐	☐
Contact me at work	☐	☐
Contact me via e-mail	☐	☐
Leave messages on my home voicemail / answering machine	☐	☐
Leave messages on my cell phone voicemail	☐	☐
Leave messages on my work voicemail / answering machine	☐	☐

PLEASE PRINT

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE ☐ YES ☐ NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S BIRTHDAY	SUBSCRIBER'S SSN / ID #
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS	

SECONDARY COVERAGE ☐ YES ☐ NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S BIRTHDAY	SUBSCRIBER'S SSN / ID #
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS	

RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTHCARE WITH

	YES	NO	OTHERS (PLEASE PRINT)
Health Care Providers	☐	☐	1.
Insurance Companies	☐	☐	2.

CONFIRMATIONS

DO YOU PREFER A CONFIRMATION CALL

☐ No, it is unnecessary ☐ Yes, it is a helpful reminder

ASSIGNMENT & RELEASE

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he so determines. In consideration of the services rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy.

I consent to making of videotapes, photographs, and x-rays before, during, and after treatment, and to use the same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

SIGNATURE - PATIENT / GUARDIAN	DATE
WITNESS SIGNATURE	DATE

DENTAL HISTORY

Referred by_____How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ ☐ ☐
2. Have you had an unfavorable dental experience? _____ ☐ ☐
3. Have you ever had complications from past dental treatment? _____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed? _____ ☐ ☐

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? _____ ☐ ☐
8. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
10 Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

BITE AND JAW JOINT

11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
12. Do you / would you have any problems chewing gum? _____ ☐ ☐
13. Do you / would you have any problems chewing bagels, baguettes , protein bars, or other hard foods? _____ ☐ ☐
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
15. Are your teeth crowding or developing spaces? _____ ☐ ☐
16. Do you have more than one bite and squeeze to make your teeth fit together? _____ ☐ ☐
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
18. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ ☐ ☐
20. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

TOOTH STRUCTURE

21. Have you had any cavities within the past 3 years? _____ ☐ ☐
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ☐ ☐
25. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ ☐
27. Do you get food caught between any teeth? _____ ☐ ☐

GUM AND BONE

28. Do your gums bleed when brushing or flossing? _____ ☐ ☐
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
30. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
31. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
32. Have you ever experienced gum recession? _____ ☐ ☐
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
34. Have you experienced a burning sensation in your mouth? _____ ☐ ☐

Patient's Signature _____ Date_____

Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury_____	☐	☐
2. an allergic reaction to		
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulpha		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent within the last six months __	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. artificial prosthesis (heart valve or joints) _____	☐	☐
8. rheumatic or scarlet fever_____	☐	☐
9. high or low blood pressure_____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. emphysema, sarcoidosis _____	☐	☐
14. tuberculosis _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. snoring, sinus)_____	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c =_____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. gastric reflux)_____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __	☐	☐
27. arthritis _____	☐	☐
28. glaucoma_____	☐	☐
29. contact lenses _____	☐	☐
30. head or neck injuries _____	☐	☐
31. epilepsy, convulsions (seizures) _____	☐	☐
32. neurologic problems (attention deficit disorder) _____	☐	☐
33. viral infections and cold sores _____	☐	☐
34. any lumps or swelling in the mouth_____	☐	☐
35. hives, skin rash, hay fever_____	☐	☐
36. venereal disease _____	☐	☐
37. hepatitis (type ___) _____	☐	☐
38. HIV / AIDS _____	☐	☐
39. tumor, abnormal growth_____	☐	☐
40. radiation therapy_____	☐	☐
41. chemotherapy_____	☐	☐
42. emotional problems _____	☐	☐
43. psychiatric treatment_____	☐	☐
44. antidepressant medication _____	☐	☐
45. alcohol / drug dependency _____	☐	☐
ARE YOU:		
46. presently being treated for any other illness _____	☐	☐
47. aware of a change in your general health _____	☐	☐
48. taking medication for weight management (i.e. fen-phen)	☐	☐
49. taking dietary supplements_____	☐	☐
50. often exhausted or fatigued _____	☐	☐
51. subject to frequent headaches _____	☐	☐
52. a smoker or smoked previously _____	☐	☐
53. considered a touchy person _____	☐	☐
54. often unhappy or depressed_____	☐	☐
55. FEMALE - taking birth control pills _____	☐	☐
56. FEMALE - pregnant _____	☐	☐
57. MALE - prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____