Vance dentistry
FAMILY · COSMETIC · IMPLANTS

Name_____Preferred to be called_____
Date of Birth_____ SS#_____Married___ Single___ Divorced__ Widowed____
Address_____City/State/Zip_____
Home#_____Work_____Cell_____ Email_____
Place of Employment_____ Occupation_____

Person responsible for account (if not patient) _____
Relationship to patient_____ Date of Birth_____ SS#_____
Home address (if different)_____
Home#_____ Work_____Cell_____Email_____

Please check any of the following you are allergic to or have had a reaction to:

___Aspirin ___Codeine ____Latex or Rubber
___Local Anesthetics (like novocaine) ____Metals, Please list_____
___Penicillin ___Sulfa Drugs ____Other, Please list_____
Please list any medications you are currently taking_____

Please check any of the following that you have currently or have had in the past:

___Artificial Cardiac Valve
___Heart Defect or Heart Murmur
___Joint Replacement or Implant
___Mitral valve Prolapse
****if you have checked any of these (or for any reason), are you required by your physician to take prophylactic antibiotics prior to dental treatment? Yes or No
Prescribing Physician_____Phone#_____
___Rheumatic Fever ___Stent Placement

Please check any of the following that you currently or have had in the past:

___Currently Pregnant or Nursing
___Anemia
___Asthma
___Currently Taking Blood Thinners
___Liver Disease
___Lupus
___Diabetes
___Pacemaker
___Heart Disease
___Hepatitis
___High Blood Pressure
___HIV/AIDS
___Kidney Trouble
___Currently taking Chemotherapy or Radiation
___Chemical Dependency
___Osteoporosis
___Epilepsy or Seizures
___Scleroderma
___Sexually Transmitted Disease
___Stroke
___Cancer type/year_____
___Mental Health Care
___Eating Disorder
___Hearing Impaired
****Please list any other medical condition that was not covered_____
_____

Treatment Assessment *Please check any of the following that pertains to you:*

Snoring
__You snore most nights
__You've been told you stop breathing or gasp in your sleep
__You currently use a CPAP

Dentures/Partials/Implants
__You have missing teeth you would be interested in replacing
__You have a denture or partial that is ill- fitting. If so, age of denture/partial _____

TMJ Disorder
___You wake up in the morning with soreness or tired feeling in your jaw
___You have frequent headaches

Cosmetic
___You would be interested in ways we can enhance your smile

Gum Disease
___You smoke
___You have been treated for gum disease

I certify that I have read and understand the above information and have answered questions accurately. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information contained in my patient file as deemed necessary by Dr. Vance. I authorize my insurance company to pay directly to Dr. Vance. I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to be responsible for payment of all services rendered on my behalf or my dependants.

Signature of Patient or Legal Guardian_____Date_____