

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 ****if you have checked any of these (or for any reason), are you required by your
 ___ Heart Defect or Heart Murmur physician to take prophylactic antibiotics prior to dental treatment? Yes or No
 ___ Joint Replacement or Implant Prescribing Physician _____ Phone# _____
 ___ Mitral valve Prolapse ___ Rheumatic Fever ___ Stent Placement _____

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

___ Currently Pregnant or Nursing ___ Hepatitis ___ Scleroderma
 ___ Anemia ___ High Blood Pressure ___ Sexually Transmitted Disease
 ___ Asthma ___ HIV/AIDS ___ Stroke
 ___ Currently Taking Blood Thinners ___ Kidney Trouble ___ Cancer type/year _____
 ___ Liver Disease ___ Currently taking Chemotherapy or Radiation
 ___ Lupus ___ Chemical Dependency ___ Mental Health Care
 ___ Diabetes ___ Osteoporosis ___ Eating Disorder
 ___ Pacemaker ___ Epilepsy or Seizures ___ Hearing Impaired
 ___ Heart Disease ****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

Cosmetic

___ You would be interested in ways we can enhance your smile

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 _____

Gum Disease

___ You smoke
 ___ You have been treated for gum disease

TMJ Disorder

___ You wake up in the morning with soreness or tired feeling in your jaw
 ___ You have frequent headaches

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 _____