Dr. Alan R. Levine and Dr. Nadine L. Vaughan

To our patients, we offer loyalty, confidentiality, competence, diligence, and our best judgment. We will treat you as we would want to be treated and be worthy of your trust. We will counsel you with respect to alternative methods to resolve your oral health issues when available. We will endeavor to achieve your objectives as expeditiously and economically as possible.

Patient Information: Please Print All Information Date_____/_____/_____

_____ ____ ____ _____/_____/_____
Name: Mr. Mrs. Ms. Miss Dr. M F Date of Birth

_____
Address City St. Zip

_____ (____)_____ (___)_____
Social Security No. Home Phone No. Cell Phone No.

_____ (____)_____
Email Address Work Phone No.

What preference do you have for confirming appointments? _____
Home, Cell, Email, Work …

_____
Employer Position

Martial Status: (Please Circle) Single Married Divorced Widowed

Names of other family members who are patients here: _____

Who referred you to our practice? _____

Spouse/Parent/Guardian Information:

_____ _____
Name Date of Birth

_____
Street Address City State Zip

_____ (____)_____ (____)_____
Social Security Home Telephone Cell Telephone

_____ (____)_____
Employer Position Work Telephone No.

_____
Employer Address

Dental Insurance:

_____ _____ _____
Ins. Company (**Primary**) Group No. ID No

_____ _____ _____
Ins. Company /Spouses (**Secondary**) Group No. ID No.

Patient Name: _____
Date: _____

PLEASE CIRCLE THE FOLLOWING (YES/NO)

NO YES Has there Been any change in your general health this year _____Explain?_____
NO YES Are you now under a physician's care: Doctor's Name_____
NO YES Have you Been Hospitalized or had a serious illness in the past five years?
NO YES Are you Pregnant?

HAVE TOU TAKEN THE FOLLOWING MEDICATIONS IN THE PAST SIX MONTHS (YES/NO):

NO YES Anticoagulants (Blood Thinners)
NO YES Blood Pressure Medication
NO YES Diuretics (Water Pill)
NO YES Steroids (e.g. Prednisone, Cortisone)
NO YES Tranquilizers (e.g. Valium, Librium)
NO YES Antidepressants (e.g. Prozac, Zoloft)
NO YES Insulin or Pill for Diabetes
NO YES Digitalis or Medication for Heart condition
NO YES Nitroglycerine
NO YES Birth Control Pills
NO YES Dilantin
NO YES Aspirin or Anti inflammatory Medications

Name of Pharmacy_____Location_____ Tel Number_____
List all other Medications you are presently taking_____
_____

HAVE YOU HAD AN ALLERGIC REACTIONTO T FOLLOWING (YES/NO):

NO YES Dental Anesthetics
NO YES Penicillin or other antibiotics
NO YES Codeine or other narcotics
NO YES Aspirin or other anti-inflammatory medications
NO YES Sulfa drugs
NO YES Food_____
NO YES Latex Gloves
NO YES Other_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING (YES/NO):

NO YES Blood disorders, anemia or leukemia
NO YES Bleeding disorders
NO YES Stomach ulcers
NO YES Colitis
NO YES Kidney trouble or renal dialysis
NO YES Hepatitis, jaundice, or liver disease
NO YES Tuberculosis
NO YES Tested Positive for HIV
NO YES Active venereal disease
NO YES Psychiatric therapy
NO YES Treatment for substance abuse
NO YES Sleep Disorders
NO YES Thyroid disease
NO YES Diabetes
NO YES Cancer
NO YES Surgery or radiation treatment for a tumor, growth, or other condition
NO YES Congenital heart defects
NO YES Mitral valve prolapse
NO YES Rheumatic heart disease/ or fever
NO YES Heart murmur
NO YES Heart condition_____
NO YES Heart attack
NO YES High Blood Pressure
NO YES Pacemaker
NO YES Prosthetic heart valve
NO YES Stroke
NO YES Arthritis
NO YES Prosthetic or replacement of bones/joints
NO YES Epilepsy
NO YES Asthma
NO YES Blood Transfusion
NO YES Have you ever been denied permission to give blood.

HAVE YOU RECENTLY EXPERIENCED ANY OF THE FOLLOWING (YES/NO):

NO YES Chest pains after mild exercise
NO YES persistent cough or coughing up blood
NO YES Frequent urination
NO YES Excessive thirst

Do you have any other disabilities that we should consider in planning your dental treatment? Yes /No
Explain_____

Do you Smoke Yes/ No What? _____ How Much? _____ How Many Years? _____
Do You Use Smokeless Tobacco Products? _____How often? _____How many years? _____
Do you Drink Alcoholic beverages? _____ How much daily? _____

Patient Name: _____
Date: _____

Oral Health History

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (YES/NO):

NO YES History of Herpes Simplex
NO YES Frequent dry mouth
NO YES Trouble with any previous dental work
NO YES Recurrent canker sores, mouth ulcers or infections
NO YES Excessive Bleeding after Extractions
NO YES Disease Condition or problem not listed

If any of the above applies please explain_____
_____

Dental Health History

DATE OF LAST DENTAL VISIT_____ DENTIST NAME: _____
HAVE YOU HAD ORTHODONTIC TREATMENT? _____ ORTHODONTIST NAME: _____
HAVE YOU HAD PERIODONTAL TREATMENT? _____ PERIODONTIST NAME: _____

Reason For your visit today: _____

What did you like most about previous dentist? _____

What did you like least about your previous dentist? _____

Is there a Reason for leaving your previous dentist? _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (YES/NO):

NO YES Dental Pain or discomfort
NO YES Problems Chewing Satisfactorily
NO YES Bleeding gums
NO YES Loose teeth
NO YES Are your teeth sensitive to hot/cold
NO YES Jaws clicking or popping when opening and or closing.
NO YES Oral or tongue habits
NO YES Dissatisfaction with the way your teeth look
NO YES Uncomfortable bite
NO YES Bad taste in your mouth or bad breath
NO YES Food trapping between your teeth
NO YES Are your teeth sensitive to sweets
NO YES Clenching or grinding your teeth
NO YES Frequent headaches or backaches

Do you brush daily? _____ Do you floss daily? _____
How often do you brush daily? _____
Are you missing any teeth? _____
Do you wear Dentures and/or Partial dentures? _____
If yes, are you satisfied with the fit? _____
Are you satisfied with your smile? _____
Are you familiar with Dental Implants? _____
Would you like to discuss Dental Implants to replace missing teeth? _____

I UNDERSTAND THE ABOVE INFORMATION IS NECESSARY TO PROVIDE ME WITH DENTAL CARE IN A AFE AND EFFICIENT MANNER. I HAVE ANSWERED ALL QUESTIONS TRUTHFULLY AND TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY THIS OFFICE IF THERE ARE ANY CHANGES IN THE ABOVE.
I ACKNOWLEDGE THAT I AM RESPOSIBLE FOR ANY FEES NOT COVERED BY INSURANCE.

SIGNATURE_____ DATE_____

THANK YOU FOR SELECTING US TO PROVIDE DENTAL CARE FOR YOU AND YOUR FAMILY

Statement of Financial Responsibility

I acknowledge that the financial responsibility for any and all charges incurred during treatment is mine. I promise to pay Levine-Vaughan Dental Associates the full amount of charges for said services upon demand or in accordance with payment arrangements agreed by them. I also acknowledge that Levine-Vaughan Dental Associates may bill my insurance as a courtesy to me, in consideration of the services rendered, but I am responsible for any fees not fully paid by my insurance plan.

Signature: _____ Date_____

Relationship_____

Insurance Authorization and Assignment Authorization

Patient name_____
(**Print Please)**

Authorization to release information:

I hereby authorize Levine-Vaughan Dental Associates to release any information acquired in the course of my examination and/ or treatment to my insurance company upon request.

_____
Signature of patient or parent of minor

Assignment of Benefits:

I hereby authorize payment directly to Levine-Vaughan Dental Associates all benefits due for services rendered.

_____
Insured Person's Signature

05/2009