Gary Vander Vliet, DMD, MAGD
PREVENTIVE, COSMETIC AND IMPLANT DENTISTRY

Patient Information

Patient Name: _____ I'd prefer to be called: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

E-Mail: _____ Fax: _____ Mobile/Cell: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Your current physical health is: ☐ **Good** ☐ **Fair** ☐ **Poor**

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over the counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one: _____

_____

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Previous/Present Dentist: _____

Last Visit Date: _____

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

☐ Y ☐ N	Abnormal Bleeding / Hemophilia	☐ Y ☐ N	Herpes / Fever Blisters
☐ Y ☐ N	AIDS / HIV	☐ Y ☐ N	High Blood Pressure
☐ Y ☐ N	Alcohol/Drug Use	☐ Y ☐ N	Hospitalized for Any Reason
☐ Y ☐ N	Anemia	☐ Y ☐ N	Kidney Problems
☐ Y ☐ N	Artificial Bones / Joints / Valves	☐ Y ☐ N	Liver Disease
☐ Y ☐ N	Asthma	☐ Y ☐ N	Low Blood Pressure
☐ Y ☐ N	Blood Transfusion	☐ Y ☐ N	Lupus
☐ Y ☐ N	Cancer / Chemotherapy	☐ Y ☐ N	Mitral Valve Prolapse
☐ Y ☐ N	Colitis	☐ Y ☐ N	Pacemaker
☐ Y ☐ N	Congenital Heart Defect	☐ Y ☐ N	Psychiatric Problems
☐ Y ☐ N	Diabetes	☐ Y ☐ N	Radiation Treatment
☐ Y ☐ N	Difficulty Breathing	☐ Y ☐ N	Rheumatic / Scarlet Fever
☐ Y ☐ N	Emphysema	☐ Y ☐ N	Seizures
☐ Y ☐ N	Epilepsy	☐ Y ☐ N	Shingles
☐ Y ☐ N	Fainting Spells	☐ Y ☐ N	Sickle Cell Disease / Traits
☐ Y ☐ N	Frequent Headaches	☐ Y ☐ N	Sinus Problems
☐ Y ☐ N	Glaucoma	☐ Y ☐ N	Stroke
☐ Y ☐ N	Hay Fever	☐ Y ☐ N	Thyroid Problems
☐ Y ☐ N	Heart Attack/Surgery	☐ Y ☐ N	Tuberculosis (TB)
☐ Y ☐ N	Heart Murmur	☐ Y ☐ N	Venereal Disease
☐ Y ☐ N	Hepatitis		

Anything you would like to discuss with the dentist in private? ☐ Yes ☐ No

Please list all serious medical condition(s) that you have ever had:

_____

Are you allergic to any of the following?

☐ Y ☐ N	Aspirin	☐ Y ☐ N	Erythromycin	☐ Y ☐ N	Penicillin
☐ Y ☐ N	Codeine	☐ Y ☐ N	Jewelry / Metals	☐ Y ☐ N	Tetracycline
☐ Y ☐ N	Dental Anesthetics	☐ Y ☐ N	Latex	☐ Y ☐ N	Other

Please list any other drugs/materials that you are allergic to: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

_____ _____
Signature of patient, parent or guardian **Date**

_____ _____
Signature of Doctor **Date**

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Cosmetic Information

If I could change my smile, I would:

- Make my teeth brighter: ☐
- Make my teeth straighter: ☐
- Close spaces: ☐
- Replace black fillings with tooth colored fillings: ☐
- Repair chipped teeth: ☐
- Replace missing teeth: ☐
- Replace old crowns that don't match: ☐
- Have a smile makeover: ☐

On a scale of 1 to 10,
with 10 being the highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

How important is a beautiful smile in your life?
1 2 3 4 5 6 7 8 9 10

How would you rate your current smile?
1 2 3 4 5 6 7 8 9 10

Referral Information

Whom may we thank for referring you to our office?

_____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

E-Mail: _____ Fax: _____ Mobile/Cell: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

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Insurance Information

Primary Insurance	**Secondary Insurance**
Dental Coverage: ☐ Yes ☐ No	Dental Coverage: ☐ Yes ☐ No
Insurance Co. Name: _____	Insurance Co. Name: _____
Insurance Co. Address: _____	Insurance Co. Address: _____
_____	_____
Insurance Co. Phone #: _____	Insurance Co. Phone #: _____
Group # (Plan, Local or Policy #): _____	Group # (Plan, Local or Policy #): _____
Insured's Name: _____	Insured's Name: _____
Relation: _____	Relation: _____
Insured's Birth Date: ____/____/_____	Insured's Birth Date: ____/____/_____
Insured's ID #: _____	Insured's ID #: _____
Insured's Employer: _____	Insured's Employer: _____
Employer's Address: _____	Employer's Address: _____
_____	_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate provided by this office for my dental care can only be extended for a period of six (6) months from the date of the patient examination.

Further, I understand and acknowledge that photographs and images of me may be shown to other patients and doctors for treatment and educational purposes and I agree to the same.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____	_____	_____
Signature of patient, parent or guardian	**Date**	**Relationship to Patient**
_____	_____	_____
Signature of guarantor of payment/responsible party	**Date**	**Relationship to Patient**