

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

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: _____

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: _____

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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Insurance Information

Primary Insurance	Secondary Insurance
Dental Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> 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