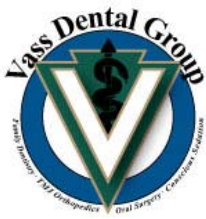


Dr. Larry I. Vass Dental Group, P.C.
New Patient Form
Welcome to Vass Dental Group!

Patient Information

Patient's Name

Last: ______ First: ______ Middle: ______ Male: ☐ Female: ☐

Address: ______ City: ______ State: ____ Zip: ____

Home phone: ______ Cell phone: ______ E-mail: ______ Birth date: ______

Check appropriate box: Minor: ☐ Single: ☐ Married: ☐ Divorced: ☐ Widowed: ☐ Separated: ☐

If patient is a student, name of school/college: ______

Who may we thank for referring you? ______

How did you hear about us? ______

Person to contact in case of an emergency: ______ Phone: ______

Responsible Party

Name of person responsible for this account

Last: ______ First: ______ Middle: ______ Male: ☐ Female: ☐

Address: ______ City: ______ State: ____ Zip: ____

Home phone: ______ Cell phone: ______ E-mail: ______ Birth date: ______

Driver's license #: ______ Social security #: ______ Currently a patient in our office: Yes: ☐ No: ☐

Employer: ______ Work phone: ______

Primary Insurance

Name of insured

Last: ______ First: ______ Middle: ______ Male: ☐ Female: ☐

Relation to patient: ______ Birth date: ______ Social security #: ______

Employer: ______ Work phone: ______ Date employed: ______

Employer address: ______ City: ______ State: ____ Zip: ____

Insurance company: ______ Group #: ______ Patient ID #: ______ Union or local #: ______

Secondary Insurance

Name of insured

Last: ______ First: ______ Middle: ______ Male: ☐ Female: ☐

Relation to patient: ______ Birth date: ______ Social security #: ______

Employer: ______ Work phone: ______ Date employed: ______

Employer address: ______ City: ______ State: ____ Zip: ____

Insurance company: ______ Group #: ______ Patient ID #: ______ Union or local #: ______

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my insurance.

______ ______ ______

Patient (Print Name) *Patient Signature* *Date*

HEALTH HISTORY

PATIENT'S NAME:____BIRTHDATE:_______________TODAY'S DATE:____________

Why have you come to see us today? (e.g.: pain, checkup, etc.)____

How did you hear about us? _____Friend ____TV Ad ____Health Magazine ____Internet __ Other _________________________

Date of last healthcare exam:____________________What was the exam for?____

Please circle Y for (Yes) or N for (No):

Y N I like my smile	Y N I prefer tooth-colored fillings	Y N My gums feel tender or swollen
Y N I have had a facial &/or jaw injury	Y N I want my teeth straight	Y N I want my teeth whiter
Y N Are you nervous seeing a dentist?	Y N Have you had bad dental experiences?	Y N Have you been hospitalized in 5 yrs?

For the following questions circle yes or no if you have or have had any of these conditions. Your answers are for our records only and will be kept confidential. Please note that during your initial visit you will be asked some questions about your responses. Our team may ask additional questions concerning your health.

Anemia or Blood Disorder?	No	Yes	Tuberculosis or Lung Disease?	No	Yes
Heart Disease?	No	Yes	Asthma?	No	Yes
Heart Murmur/Mitral Valve prolapse?	No	Yes	Hay Fever?	No	Yes
Heart Stent? When Placed__________________?	No	Yes	Sinus Trouble?	No	Yes
Congenital heart lesions?	No	Yes	Epilepsy of Seizures?	No	Yes
Rheumatic Fever?	No	Yes	Ulcers?	No	Yes
High or Low Blood Pressure?	No	Yes	Implants/Artificial Joints? 0 Hip/ 0 Knee/ 0 Other	No	Yes
Prolonged Bleeding Time?	No	Yes	Liver Disease or Jaundice?	No	Yes
Diabetes?	No	Yes	Hepatitis (Type_________)?	No	Yes
Excessive urination &/or Thirst?	No	Yes	Infectious Mononucleosis (Mono)?	No	Yes
Herpes?	No	Yes	Shingles?	No	Yes
Arthritis?	No	Yes	Kidney Disease?	No	Yes
Sexually Transmitted Disease/Venereal Disease?	No	Yes	Cancer/Malignancy/Tumor?	No	Yes
History of Drug Addition?	No	Yes	Chemotherapy or Radiation Therapy?	No	Yes
AIDS?	No	Yes	Immune Suppressed Disorder?	No	Yes
Hearing Loss	No	Yes	Glaucoma?	No	Yes
History of Emotional or Nervous Disorders?	No	Yes	Stroke?	No	Yes
I Smoke or Use Tobacco. How Many Years______?	No	Yes	Do You consume Alcohol? Drinks per week______?	No	Yes
Do You Take Antibiotics Prior to Dental Treatment?	No	Yes	Have You Ever Taken Fen-Phen or Redux?	No	Yes
WOMEN: Are You Taking birth Control Medication?	No	Yes	**WOMEN:** Are You or Could You be Pregnant?	No	Yes
No or Yes: Do you have any medical problem or medical history **NOT** listed on this form? List:					

Are you allergic to any of the following? Please circle Yes or No:

Aspirin	No	Yes	Ibuprofen/Motrin	No	Yes
Sulfa Drugs/Sulfites/Sulfides	No	Yes	Penicillin or Related antibiotics	No	Yes
Codeine	No	Yes	Oxycodone/Percocet/Vicodin	No	Yes
Latex/Metals/Plastics	No	Yes	Local anesthetics (Like Novocaine)	No	Yes
Valium or Other Sedatives	No	Yes	Other (Please Specify)	No	Yes

Please List all medications you are currently taking:____

____

Physician's Name____***Phone #***______________________***Fax***__________________

Physician's Address____

In the Event of an Emergency please contact

Name____***Relationship***_________***Phone***_________________________________

Name____***Relationship***_________***Phone***_________________________________

Please turn page over, complete, date, and sign.

Head Health History

Please review & answer Yes or No to each question and check appropriate space.

#	Questions			Comments
1.	Have you noticed a change in your bite? Do you feel your teeth hit first on the right _________or on the left________ ? Do you hit more on your back teeth ________or on your front teeth__________?	Yes	No	
2.	Are you aware of any of the following in your jaw joints? Popping/Clicking______ Grinding noises in joint__________	Yes	No	
3.	Do you have difficulty or pain opening wide?_______ or chewing________?	Yes	No	
4.	When you awaken, do your jaw joints or facial or neck muscles feel sore ?	Yes	No	
5.	Do you snore at night?	Yes	No	
6.	Do your jaw joints or muscles feel stiff, tight, or tired after eating?	Yes	No	
7.	Do you grind or clench your teeth at night_____ or during the day______?	Yes	No	
8.	Do y our gums bleed after brushing?	Yes	No	
9.	Do you experience pain in your Jaw___? Face___? Neck___? Shoulder____?	Yes	No	
10.	Do you get headaches________? Migraines________? How many headaches per week_________/per month___________?	Yes	No	
11.	Do you have any ringing_______? Or fullness________ in your ears?	Yes	No	
12.	Do you ever get dizzy_________? Or Sea Sick__________?	Yes	No	
13.	Do you ever feel anxiety________? Or Stressed_________? How would you rate your stress level? Mild___? Moderate___? Severe____?	Yes	No	
14.	Have you had braces or orthodontic Treatment? Date__________________	Yes	No	
15.	Have you ever worn a Bite Splint________? Or a Retainer______________?	Yes	No	
16.	Have you ever had a car accident________? Or trauma to your head_____? If yes, describe & date____	Yes	No	
17.	Have you ever had a sports injury?__________________________________	Yes	No	
18.	Do you restrict or avoid normal activities due to pain or symptoms?	Yes	No	
19.	Do you spend 4+ hours in an abnormal postural position daily?	Yes	No	

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information is needed, you have my permission to ask the respective health care provide or agency, who may release such information to you. I will notify the doctor of any change in my health and medication. Dr. Larry Vass has my permission to treat me for my oral health needs.

______________________________________ ___________________________________ ____________________

Patient (Print Name) **Patient or Guardian Signature** **Date**

_______________________________________ ________________ __________________ ___________________

Doctor Signature **Date** **Date** **Date**

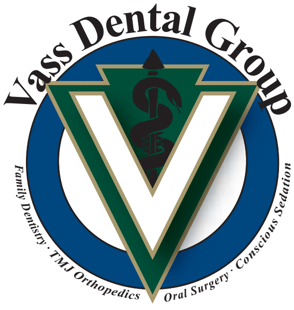
____________________ ____________________ __________________ __________________________

Date **Date** **Date** **Date**

Doctor's Notes

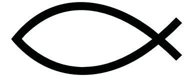
____

____



Dr. Larry I. Vass Dental Group, P.C.

Family Dentistry • TMJ Orthopedics • Oral Surgery • Conscious sedation



Financial Policy

Dear: Patient

We are pleased to welcome you as a new patient. Our primary mission at Dr. Vass' office is to deliver the best and most comprehensive dental care available. An important part of this mission is making the cost of optimal care as easy and manageable for our patients as possible.

To assist you with your dental care investment, we provide the following payment options:

1. Cash - includes money orders and personal checks.

2. Visa/MasterCard/Discover - we accept credit cards as payment for treatment.

3. CareCredit® - patient payment plans that allow you to pay over time with convenient low minimum monthly payments. With CareCredit, you enjoy these benefits:*
o Flexible financing options
o No annual fees or prepayment penalties
o Quick and easy application
o Receive a credit decision almost immediately
o Start your recommended treatment immediately*

We are happy to offer these choices so that you can select a payment option that best fits your needs. We have enclosed more information on CareCredit so that you are able to make an informed decision about which payment option you prefer.

Please circle your choice, sign below and return to manager before treatment.

Again, we are pleased to welcome you as a patient to our practice.

Sincerely, Dr. Larry I. Vass

____
Print your name here sign below

X ____________________________ Date_________

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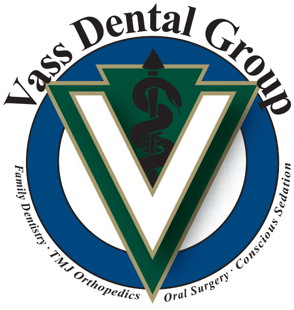
www.vassdentalgroup.com • drvass@vassdentalgroup.com



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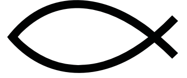

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ________________________________, have received a copy of this office's Notice of Privacy practices.

____
(Please Print Name)

____
(Signature)

____
(Date)

For Office Use Only

We attempted to Obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign
___ Communication barriers prohibited obtaining the acknowledgement
___ An emergency situation prevented us from obtaining acknowledgement
___ other (Please Specify)

____
____
____
____
____

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