



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

Name _____ Date _____

Date of last health care exam: _____ What was this exam for? _____

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: _____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychosis	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Rheumatic Fever	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Other Conditions	No	Yes
Heart Stent? When placed?	No	Yes	Recurrent Illnesses	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet [®] (cimetidine) or Prilosec [®] (omeprazole)?	No	Yes
Antacids?	No	Yes	Cardizem [®] (diltiazem) or Calan, Isoptin [®] (Verapamil)?	No	Yes
Dilantin [®] or Tegretol [®]	No	Yes	Serzone [®] (nefazodone)	No	Yes
Barbiturates (any)	No	Yes	Diflucan [®] (fluconazole) or Sporonox [®] (itraconazole)	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Biaxin [®] (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax [®] , Aredia [®] , Zometa [®] , Actonel [®] , Boniva [®])? If so, when did the treatment begin?			When did the treatment end?	No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Please list any medications you are currently taking and dosages:

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |

Please list any dietary or herbal supplements you are taking, and for what purpose:

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Women: Are you pregnant? No Yes
 If no, are you planning a pregnancy in the near future? No Yes
 Are you a nursing mother? No Yes
 Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes
 Have you ever received a diagnosis of "high blood pressure"?
 What is your normal blood pressure? S /D Today: _____/_____

Are you allergic or have you had a reaction to:
 a. Local anesthetics No Yes
 b. Penicillin or other antibiotics No Yes
 c. Aspirin, Ibuprofen or Tylenol No Yes
 d. Codeine, Valium® or other sedatives..... No Yes
 e. Latex or Metals
 f. Other (please specify)_____

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

Weight and Diet considerations

Weight	Meals per Day	Dietary Restrictions	Food Allergies

Sugar in your diet (circle one): none slight moderate high

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

Significant findings from questionnaire or oral interview:

Dental management considerations:

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 change in my health and medication.

 Patient (Print Name)

 Patient Signature

 Date

 Doctor (Print Name)

 Doctor Signature

 Date

Updates:

 date:_____

 date:_____

 date:_____

 date:_____

 date:_____

 date:_____



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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**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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