***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.

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**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 physicians 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 Insulin or Pill for Diabetes

NO YES Blood Pressure Medication NO YES Digitalis or Medication for Heart condition

NO YES Diuretics (Water Pill) NO YES Nitroglycerine

NO YES Steroids (e.g. Prednisone, Cortisone) NO YES Birth Control Pills

NO YES Tranquilizers(e.g. Valium, Librium) NO YES Dilantin

NO YES Antidepressants (e.g. Prozac, Zoloft) 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 Sulfa drugs

NO YES Penicillin or other antibiotics NO YES Food\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NO YES Codeine or other narcotics NO YES Latex Gloves

NO YES Aspirin or other anti-inflammatory medications 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 Congenital heart defects

NO YES Bleeding disorders NO YES Mitral valve prolapse

NO YES Stomach ulcers NO YES Rheumatic heart disease/ Rheumatic fever

NO YES Colitis NO YES Heart murmur

NO YES Kidney trouble or renal dialysis NO YES Heart condition\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NO YES Hepatitis, jaundice, or liver disease NO YES Heart attack

NO YES Tuberculosis NO YES High Blood Pressure

NO YES Tested Positive for HIV NO YES Pacemaker

NO YES Active venereal disease NO YES Prosthetic heart valve

NO YES Psychiatric therapy NO YES Stroke

NO YES Treatment for substance abuse NO YES Arthritis

NO YES Sleep Disorders NO YES Prosthetic or replacement of bones/joints

NO YES Thyroid disease NO YES Epilepsy

NO YES Diabetes NO YES Asthma

NO YES Cancer NO YES Blood Transfusion

NO YES Surgery or radiation treatment for NO YES Have you ever been denied permission

a tumor, growth, or other condition to give blood.

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

NO YES Chest pains after mild exercise NO YES Frequent urination

NO YES persistent cough or coughing up blood 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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 Recurrent canker sores, mouth ulcers or infections

NO YES Frequent dry mouth NO YES Excessive Bleeding after Extractions

NO YES Trouble with any previous dental work 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 Dissatisfaction with the way your teeth look

NO YES Problems Chewing Satisfactorily NO YES Uncomfortable bite

NO YES Bleeding gums NO YES Bad taste in your mouth or bad breath

NO YES Loose teeth NO YES Food trapping between your teeth

NO YES Are your teeth sensitive to hot/cold NO YES Are your teeth sensitive to sweets

NO YES Jaws clicking or popping when opening NO YES Clenching or grinding your teeth

and or closing. NO YES Frequent headaches or backaches

NO YES Oral or tongue habits

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