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 (**Primary**) Group No. ID No

_____ _____ _____

Ins. Company /Spouses (**Secondary**) Group No.

ID No.

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 a tumor, growth, or other condition NO YES Have you ever been denied permission to give blood.

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

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? _____

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 and or closing. NO YES Clenching or grinding your teeth

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.

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

LEVINE-VAUGHAN DENTAL ASSOCIATES
2018 Naamans Road, Suite 2
Wilmington, DE 19810
(302) 475-3743

CANCELLATION & NO-SHOW POLICY

We appreciate you and understand your time is valuable which is why we make every effort to keep you from waiting. As a result, your appointment time in this office is reserved exclusively for you. We reserve the right to charge patients who do not cancel with adequate notice or who fail to keep their scheduled appointments. To respect the needs of all Levine Vaughan Dental Associate patients, if it is necessary to cancel your reserved appointment, we require that you contact our office **48 hours** in advance. Appointments are in high demand and your early cancellation will give another person the opportunity to access timely dental care.

A "no- show" appointment occurs when a patient misses an appointment without cancelling 48 hours in advance. ***Missed*** appointments are an inconvenience to patients who need access to dental care in a timely manner; is inconsiderate to our doctors and team who are left sitting idle. Last minute/late cancellations are considered "no-show" appointments. We reserve the right to charge any appointment(s) broken without 48 hours' notice. **The charge will be $50. These fees are not covered by insurance and are the sole responsibility of the patient. Fees must be paid in full prior to the patient's next appointment.** Habitual missed/cancelled/rescheduled appointments may result in a patient being required to either pay up front prior to scheduling an appointment or this office may no longer be available to provide dental services for the patient.

Our voicemail is available for messages left after business hours, however if a message is left after business hours cancelling an appointment for the next day this will be subject to our fee. We understand that extreme/unavoidable emergencies or circumstances do arise which may require you to cancel your appointment, and individual circumstances will be taken into consideration.

Our practice passionately believes that good doctor/patient relationship is based on trust and good communication.

By signing below, I acknowledge receipt of Levine Vaughan Dental Associates Policy.

_____
Patient or legally authorized individual signature

_____
_____
Signature Date