Vance dentistry
FAMILY · COSMETIC · IMPLANTS

Name____Prefer to be called____________________
Date of Birth_______________ SS#____________________Married___ Single___ Divorced__ Widowed__
Address____
City/State/Zip______________________________________ Email ______________________________
Home#___________________________Work_________________________Cell__________________
Place of Employment______________________________Occupation__________________________

Person responsible for account (if not patient) ____
Relationship to patient_________________________Date of Birth______________ SS# ______________
Home address (if different)____
Home#______________Work_________________Cell________________Email_____________________

Please check any of the following you are allergic to or have had a reaction to:

___Aspirin ___Codeine ____Latex or Rubber
___Local Anesthetics (like novocaine) ____Metals, Please list_________________________________
___Penicillin ___Sulfa Drugs ____Other, Please list__________________________________

Please list any medications you are currently taking:____
____

Please check any of the following that you have currently or have had in the past:

___Artificial Cardiac Valve
___Heart Defect or Heart Murmur
___Joint Replacement or Implant
___Mitral valve Prolapse
___Rheumatic Fever
___Stent Placement

****if you have checked any of these (or for any reason), are you required by your physician to take prophylactic antibiotics prior to dental treatment? Yes or No
Prescribing Physician___________________________________
Phone #____

Please check any of the following that you currently or have had in the past:

___Currently Pregnant or Nursing ___Hepatitis ___Scleroderma
___Anemia ___High Blood Pressure ___Sexually Transmitted Disease
___Asthma ___HIV/AIDS ___Stroke
___Currently Taking Blood Thinners ___Kidney Trouble ___Mental Health Care
___Liver Disease ___Currently taking Chemotherapy or Radiation
___Lupus ___Chemical Dependency ___ Cancer type/year_____________
___Diabetes ___Osteoporosis ___Eating Disorder
___Pacemaker ___Epilepsy or Seizures ___Hearing Impaired
___Heart Disease

****Please list any other medical condition that was not covered:**
____
____

Treatment Assessment
Please check any of the following that pertains to you:

Snoring
__Do you snore most nights
__Have you been told you stop breathing or gasp in your sleep
__Do you currently use a CPAP

Cosmetic
___Would you be interested in ways we can enhance your smile

Dentures/Partials/Implants
__Do you have missing teeth you would be interested in replacing
__Do you have a denture or partial that is ill- fitting. If so, age of denture/partial____

Gum Disease
___Have you been treated for gum disease
___Do you smoke

TMJ Disorder
___Do you wake up in the morning with soreness or tired feeling in your jaw
___Do you have frequent headaches

I certify that I have read and understand the above information and have answered questions accurately. I understand that providing incorrect information can be dangerous to my health.

Signature of Patient or Legal Guardian____
Date_________________

Financial Policy

To provide the highest quality dental care, we provide our patients with an estimated fee. Please review the following options:

1. Co-payments from patients with insurance coverage are expected at the time of treatment.
2. Patients without insurance coverage are responsible for payment in full at time of services rendered.
3. We accept all major credit cards: Visa, Mastercard, American Express and Discover. For your convenience a credit card may be kept on file for any agreed upon charges.
4. Interest free extended payment plans are available through Care Credit.
5. A third-party fee will be assessed once an account is turned over to collection. You will be responsible for all third-party fees.

Signature____Date_____________________

Insurance Policy

Providing accurate insurance information will allow us, as a courtesy, to file your claim in a timely manner and to maximize your benefits but be advised this is an agreement between you and your insurance company. However, if we do not receive your payment from your insurance carrier with 90 days, you will be responsible for all fees for services rendered. Because we cannot guarantee your benefits it is in your best interest to familiarize yourself with the terms of your policy.

Signature____Date____________________

Cancellation Policy

Your dental needs are a priority therefore, it is important that you keep your dental appointment to maintain optimal dental health. However, we understand there are times when an appointment must be changed. To accommodate other patients and avoid any unnecessary cancellation fees we require a 24-hour cancellation notice. If a 24-hour notice is not given, you will be charged a $75.00 missed appointment/late cancellation fee.

Signature____Date_____________________

Privacy Policy

I, ______________________________________, give permission for Dr. Vance and his staff to share my information with the following people.

____

____

_____ I do not want my information shared with anyone.

Signature____Date_____________________