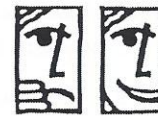


Antioch Dental Care



Welcome to the Office of Yiannis A. Vlahos, D.D.S. and Charlene N. Tran, D.D.S. Your confidential answers to the following questions will help us provide the best possible dental care for YOU and your family.

Patient Information

Date: _____
Patient's Name: _____ Birthdate: _____
First Middle Last
If child, Parent's/Guardian's Name: _____
Address: _____
Street City State Zip
Home Phone: _____ Work Phone: _____ Social Security #: _____
Employer: _____ Occupation: _____ No. of years employed: _____
Name of nearest relative not living with you: _____
Complete Address: _____
Whom may we thank for your referral: _____

Spouse Information

Name: _____ Birthdate: _____
First Middle Last
Address: _____
Street City State ZIP
Home Phone: _____ Work Phone: _____ Social Security #: _____
Employer: _____ Occupation: _____ No. of years employed: _____

Insurance Information

Insured's Name: _____ Insured's Soc. Sec. #: _____
Insurance Company: _____ Group #: _____
Insurance Company Address: _____ Phone #: _____
Is policy affiliated with Union? Yes ___ No ___ Union Name: _____ Local #: _____
Do you have Dual coverage? Yes ___ No ___ If yes, please complete the following:
Insured's Name; _____ Social Security #: _____
Insurance Company: _____ Group #, _____ Local #: _____
Insurance Company Address: _____ Phone #: _____

Dental Information

Are you having pain or discomfort at this time? Yes ___ No ___
Do your gums bleed while brushing? Yes ___ No ___
Are your teeth sensitive to hot or cold? Yes ___ No ___
Do you grind or clench your teeth? Yes ___ No ___
Do you have headaches or sorejaw? Yes ___ No ___
Do you have any fear of dental work? Yes ___ No ___
Date of your last dental exam: _____
Type of treatment at that time: _____

We accept all major credit cards.
Would you prefer to finance your dental treatment? YES/ NO

Explain your current dental problem- _____
How do you feel about the appearance of your teeth? _____

