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: _____ (First / Middle / Last) Birthdate: _____

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: _____ (First / Middle / Last) Birthdate: _____

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 ___

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

Date of your last dental exam: _____

Type of treatment at that time: _____

Explain your current dental problem- _____

How do you feel about the appearance of your teeth? _____

OVER>

Medical Information

1. Have you been in the hospital during the past two years? Yes__ No__
2. Have you been or are you under the care of a medical doctor'? Yes__ No__

   Physician's Name: _____ Phone #: _____
3. Are you currently taking medications or drugs? Yes__ No__

   If yes, please list: _____
4. Are you sensitive or allergic to any medications? Yes__ No__

   If yes, please list: _____
5. Indicate which of the following pertain to you. Please circle Yes or No to each item.

Heart Failure Yes No	Artificial Joints (Hip, Knee, ect.,	Hepatitis B (Serum) Yes No
Heart Disease Yes No	Pins, screws, rods) Yes No	Mononucleosis Yes No
Angina Pectoris Yes No	Allergic to Latex or Acrylic Yes No	Venereal Disease Yes No
Congenital Heart Disease Yes No	Have you taken Phen-fen Yes No	A.I.D.S. Yes No
Heart Murmur-Age____ Yes No	Diabetes/insulin Dep.?. Yes No	H.I.V. Positive Yes No
Mitral Valve Prolaspe Yes No	Thyroid Problems Yes No	Cold Sores/Fever Blisters Yes No
Arteriosclerosis Yes No	Kidney Trouble Yes No	Blood Transfusion Yes No
Open Heart Surgery. Yes No	Asthma Yes No	Hemophillia Yes No
Angioplasty Yes No	Hay Fever. Yes No	Anemia Yes No
Artificial Heart Valve Yes No	allergies or Hives Yes No	Sickle Cell Disease Yes No
Heart Pacemaker Yes No	Sinus Problems Yes No	Bruise Easily. Yes No
Stroke Yes No	Tuberculosis Yes No	Liver Disease Yes No
Rheumatic Fever-Damage?. Yes No	Chronic Cough Yes No	Nervousness Yes No
High Blood Pressure Yes No	Emphysema Yes No	Epilepsy or Seizures Yes No
Arthritis Yes No	Cancer Yes No	Fainting or Dizzy Spells Yes No
Rheumatism Yes No	Radiation Therapy Yes No	Breast Cancer treatment Yes No
Cortisone Medicine Yes No	Chemotherapy Yes No	Osteoporosis medications Yes No
Drug or Alcohol Addiction Yes No	Hepatitis A (infectious) Yes No	Developmentally Disabled ----- Yes No

6. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? Yes No
7. Do your ankles swell during the day? Yes No
8. Do you use more than two pillows to sleep? -Yes No
9. Do you wake up and feel short of breath? Yes No
10. Do you have/had, any disease, condition not listed? Yes No

    If yes, please list: _____

COMMENTS (OFFICE USE ONLY)

11. Are you pregnant? ☐ Yes, what month? _____ ☐ No 12. Are you nursing? ☐ Yes ☐ No
13. Are you taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

*Patient Signature: _____ Date, _____

CONSENT:

1. The undersigned hereby authorizes the doctor to take X-rays, study models, photographs, or other any diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patients's dental needs.
2. 1 also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____ I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor can choose and employ such assistance as deemed fit to provide recommended treatment.
3. 1 understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that 11/2% finance charge **(18% APR) may be added to my account.**
4. Lastly, I understand that where appropriate, credit bureau reports may be obtained.

* Patient or Responsible Party* _____ Date: _____

Please call 24 hours in advance to change your appointment to avoid a cancellation fee