



Vaughn Family Dentistry
965 White Plains Road
Trumbull, CT 06611
 (203)261-2511

Patient Information

Patient Name: _____ Date: 07/06/2004
 Last, First MI (Preferred Name)
 Birth Date: _____ Social Security #: _____ Gender: __ Family Status: _____
 Phone (Home): _____ (Work): _____ Ext: _____
 E-mail address: _____ Drivers License _____
 Address: _____
 Street Apartment #
 City State Zip Code

Referral Information

Whom may we thank for referring you to our practice: _____
 Another patient, friend Another patient, relative Dental Office Yellow Pages Newspaper
 School Work Other _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tuberculosis |
| | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> PREMEDICATION | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | for? | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation Treatment | OTHER: |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stomach Problems | |

- List any Medications you are now taking _____
- Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____
- Have you ever had an allergic reaction to any medication? Yes No
If yes, what medication(s)? _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____
- Are you now under the care of a physician? Yes No
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____



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Do you have other family members that are already attending our practice? If yes, whom? _____

Spouse or Responsible Party Information

The following is for: the patient's spouse **and/or** the person responsible for payment. **Please check all that apply.**

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #
City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____



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Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental insurance services are furnished as a ***courtesy***. We can not guarantee payments from insurance companies. Responsible person(s) will be expected to pay any amounts not covered by insurance. Any balances quoted are only ***estimates*** of insurance coverage and amounts due from patients. The balances are subject to change as insurance payments are received. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I understand that 48 hours notice is needed when canceling an appointment. If less than 48 hours notice is given, there is a \$50.00 late cancellation fee.

I have read the above conditions of treatment and payment and agree to abide by these conditions.

Print Name: _____ Date: _____

Relationship to Patient: _____
Signature of patient, parent, or guardian