James M. Vlassis, DDS, MS, PC
Periodontics and Implantology

First Name_____ MI_____ Last Name_____ Sex M F Date of Birth_____

Preferred Name_____SS#_____-_____-_____ Address_____City_____

State_____ Zip Code _____Home Phone _____Work Phone_____Cell Phone_____

Email_____Occupation _____Employer_____

Emergency Contact (Not Living With You) _____Phone #_____

Marital Status_____ Name of Spouse/Parent_____ Referred By_____

Are You In Good Health? _____ Yes No Changes in Health Last Year? _____ Yes No

Name Of Physician_____City_____ Office Phone Number _____

Do You Have Dental Insurance Yes No If So, Please fill out reverse side.

What pharmacy do you use?_____Pharmacy Phone Number_____

Circle yes or no for any of the following that you have had or suspect having. Use lines for explanations:

yes no DO YOU PREMEDICATE FOR DENTAL VISITS? Please indicate medication_____
yes no Damaged heart valves, artificial heart valves, heart murmur, etc._____
yes no Rheumatic Fever_____
yes no Cardiovascular Disease, heart attack, stroke, high blood pressure, etc_____
yes no Allergies_____
yes no Fainting spells or seizures_____
yes no Diabetes_____
yes no Hepatitis, Jaundice, or Liver Disease_____
yes no Kidney Trouble_____
yes no Tuberculosis_____
yes no Epilepsy_____
yes no Cancer_____
yes no Bleeding Disorders_____
yes no HIV or other Immunosuppressive Disorders_____
yes no Are you taking any Medication? (Please list on attached sheet)
yes no Are you allergic to any MEDICATION? (Please list on attached sheet)
yes no Are you allergic to LATEX?_____
yes no Are you wearing contact lenses?_____
yes no Do your gums bleed, feel tender, or irritated?_____
yes no Are you aware of grinding or clenching of your teeth?_____
yes no Do you floss regularly?_____
yes no Do you have hip, knee or joint replacement or a pacemaker?_____
yes no Do you smoke cigarettes or use tobacco products?_____
yes no WOMEN-Are you pregnant or nursing?_____

TO THE BEST OF MY KNOWLEDGE ALL THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF THERE IS A CHANGE IN MY HEALTH OR MEDICATIONS, I WILL INFORM THE DENTIST AT MY NEXT APPOINTMENT. I UNDERSTAND THAT MY DENTAL INSURANCE, IF APPLICABLE, IS A CONTRACT BETWEEN MYSELF AND MY INSURANCE CARRIER, NOT THE DOCTOR AND MY INSURANCE CARRIER, AND I AM FULLY RESPONSIBLE FOR ALL DENTAL FEES. I FURTHER UNDERSTAND THAT I WILL BE CHARGED INTEREST ON ALL PAST DUE BALANCES AND, IF NEEDED, I WILL PAY ALL LEGAL AND COLLECTION FEES ON MY ACCOUNT.

PATIENT SIGNATURE_____DATE_____
(Parent Signature if minor)

PRIMARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME : _____ RELATION TO PATIENT : _____

SS NUMBER: ___-__-____ DATE OF BIRTH : __-__-____

EMPLOYER : _____ INSURANCE COMPANY : _____

INSURANCE ADDRESS/ P.O. BOX: _____

SUBSCRIBER ID : _____ GROUP NUMBER : _____

SECONDARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME : _____RELATION TO PATIENT : _____

SS NUMBER : ___-__-____ DATE OF BIRTH : __-__-____

EMPLOYER : _____ INSURANCE COMPANY : _____

INSURANCE ADDRESS/ P.O. BOX : _____

SUBSCRIBER ID : _____ GROUP NUMBER : _____

First Name:_____ Last Name: _____ Date: _____

LIST OF MEDICATIONS

Name of Medication	Milligrams	Dosage	Reason for Taking

LIST OF ALLERGIES TO MEDICATIONS

LIST OF PHYSICIANS PHONE NUMBERS
