Vingelis Lee
PEDIATRIC & FAMILY DENTISTRY
Dr. Kristina Vingelis • Dr. Timothy Lee

WELCOME

Tell Us About You

Today's Date: _____ Email Address: _____

Name: _____ I Prefer to be called: _____ Male: ☐ Female: ☐
Last First M.I. Mr. Mrs. Ms. Dr.

Birthdate: ___/___/___ Age: _____ Social Security #: _____ Single: ☐ Married: ☐ Divorced: ☐ Widowed: ☐ Separated: ☐

Home Address: _____
Street City State Zip

Home Phone #: (___) _____ Mobile/ Pager #: (___) _____ Work #: (___) _____ Ext: _____ Driver License #: _____

Where and when are best times to reach you? _____ Whom may we thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/ PO Box City State Zip

Neighbor or Relative Not Living With You

His/ Her Name: _____ Relation: _____ Work Phone #: (___) _____ Home Phone #: (___) _____

Address: _____
Street City State Zip

Person Responsible for Account if Other Than Yourself

Name: _____ Relation: _____ Home Phone #: (___) _____ Social Security #: _____

Employer: _____ Work Phone #:(___) _____ Ext: _____ Driver's License #: _____

Billing Address: _____
Street City State Zip

Spouse Information

His/ Her Name: _____ Birthdate: ___/___/___ Social Security #: _____

Employer: _____ Work Phone #: (___) _____ Ext: _____ Driver's License #: _____

Insurance Information

Primary Insurance Medical Coverage? Yes: No: Dental Coverage? Yes: No: Orthodontic Coverage? Yes: No:

Insurance Co. Name: _____ Phone #: (___) _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/ PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthday: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/ PO Box City State Zip

Secondary Insurance Medical Coverage? Yes: No: Dental Coverage? Yes: No: Orthodontic Coverage? Yes: No:

Insurance Co. Name: _____ Phone #: (___) _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/ PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthday: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/ PO Box City State Zip

Medical History

Do you have a personal physician? Yes: ☐ No: ☐ Physician's Name:

Address: _____
Street City State Zip

Phone #: (___) _____ Date of Last Visit: _____

Your current physical health is: Good: ☐ Fair: ☐ Poor: ☐

Are you currently under the care of a physician? Yes: ☐ No: ☐ Please Explain: _____

Do you smoke or use tobacco in any form? Yes: ☐ No: ☐

CONTINUED ON BACK

Medical History

CONTINUED

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Sedatives
Y	N	Barbiturates	Y	N	Jewelry	Y	N	Sulfa Drugs
Y	N	Codeine	Y	N	Latex	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Penicillin	Y	N	Other

Please list additional drugs/ materials that cause allergic reactions: _____

For Women:

Are you taking birth control pills? Yes: ☐ No: ☐ Are you pregnant? Unsure: ☐ Yes: ☐ No: ☐ Week #: ____ Are you nursing? Yes: ☐ No: ☐

Are You Taking Any of The Following?

Y	N	Acetaminophen	Y	N	Aspirin	Y	N	Cold Remedies	Y	N	Nitroglycerin
Y	N	Antibiotics	Y	N	Blood Thinners	Y	N	Digitalis/ Heart Medication	Y	N	Recreational Drugs
Y	N	Antihistamines	Y	N	Blood Pressure Medication	Y	N	Insulin/ Diabetes Drugs	Y	N	Steroids/ Cortisone
Y	N	Thyroid Medicine	Y	N	Tranquilizers						

Are you taking any prescription/ over-the-counter-drugs not listed above? Yes: ☐ No: ☐ If yes, please list each one: _____

_____

Do You or Have You Experienced the Following?

Y	N	Abnormal Bleeding	Y	N	Difficulty Breathing	Y	N	Hepatitis	Y	N	Radiation Treatment
Y	N	Alcohol Abuse	Y	N	Drug Abuse	Y	N	Herpes	Y	N	Rheumatic Fever
Y	N	Anemia	Y	N	Emphysema	Y	N	High Blood Pressure	Y	N	Scarlet Fever
Y	N	Arthritis	Y	N	Epilepsy	Y	N	HIV+/ AIDS	Y	N	Seizures
Y	N	Artificial Bones/ Joints	Y	N	Fainting Spells	Y	N	Hospitalized for Any Reason	Y	N	Shingles
Y	N	Artificial Valves	Y	N	Fever Blisters	Y	N	Kidney Problems	Y	N	Sickle cell Disease
Y	N	Asthma	Y	N	Glaucoma	Y	N	Liver Disease	Y	N	Sinus Problems
Y	N	Blood Transfusion	Y	N	Hay Fever	Y	N	Low Blood Pressure	Y	N	Stroke
Y	N	Cancer	Y	N	Headaches	Y	N	Lupus	Y	N	Thyroid Problems
Y	N	Chemotherapy	Y	N	Heart Attack	Y	N	Mitral Valve Prolapse	Y	N	Tonsillitis
Y	N	Chicken Pox	Y	N	Heart Murmur	Y	N	Pacemaker	Y	N	Tuberculosis (TB)
Y	N	Colitis	Y	N	Heart Surgery	Y	N	Persistent Cough	Y	N	Ulcers
Y	N	Congenital Heart Defect	Y	N	Hemophilia	Y	N	Psychiatric Problems	Y	N	Venereal Disease
Y	N	Diabetes									

Please list any serious medical condition(s) that you have experienced: _____

_____

Dental History

Why have you come to the dentist today? _____

_____

Are you currently in pain? Yes: ☐ No: ☐

Do you require antibiotics before dental treatment? Yes: ☐ No: ☐

Have you experienced problems associated with any previous dental work? Yes: ☐ No: ☐

Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ/ TMD)? Yes: ☐ No: ☐

Your current dental health is? Good Fair Poor

Do you floss daily? Yes: ☐ No: ☐ Brush Daily? Yes: ☐ No: ☐

Type of bristles on your toothbrush? Hard Medium Soft

How long do you use a toothbrush before replacing it? _____

Do you use anything in addition to your toothbrush and floss? Yes: ☐ No: ☐

If yes, what? _____

Would you like fresher breath? Yes: ☐ No: ☐ Whiter teeth? Yes: ☐ No: ☐

Do your gums ever bleed? Yes: ☐ No: ☐ Ever Itch? Yes: ☐ No: ☐

Have you ever had periodontal disease? Yes: ☐ No: ☐

Do you have mobility in your teeth? Yes: ☐ No: ☐

Are your teeth sensitive to heat, cold, or anything else? _____

Do you still have wisdom teeth? Yes: ☐ No: ☐

If yes, why? _____

Previous/ Present Dentist: _____ Date of Last Visit: ____
(Please Circle)

Why did you leave your previous dentist? _____

_____

What did you like most and least about any dentist you have seen? _____

_____

Are you happy with the way your smile looks? Yes: ☐ No: ☐

If not, what would you change? _____

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

My method of payment will be _____

_____
Signature Date

PAYMENT IS DUE AT TIME OF SERVICE

I certify that I am covered by _____ Insurance company and I assign directly to Dr. _____ all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature Date