Gregory Evans
Family Dentistry

NEW PATIENT REGISTRATION FORM

Child Registration

Please print out and fill in the 2 page form and
bring with your on your first visit.

PATIENT REGISTRATION FORM

Child's Name ______________________________ Birthdate ______________________

Social Security No. ______________________________ Home Phone (   ) ______________

Home Address ______________________ City ______________ State ________ Zip ________

Mailing Address ______________________ City ______________ State ________ Zip ________

Father's Name ______________________________ Birthdate ______________________

Father's Employer ______________________________ Work Phone (   ) ______________

Address ______________________ City ______________ State ________ Zip ________

Father's Social Security No. ______________________________

Mother's Name ______________________________ Birthdate ______________________

Mother's Employer ______________________________ Work Phone (   ) ______________

Address ______________________ City ______________ State ________ Zip ________

Mother's Social Security No. ______________________________

Name of Person Providing Insurance ______________________________

Name of Insurance Company ______________________________

Address ______________________ City ______________ State ________ Zip ________

Phone (   ) ______________________ Group Number ______________________

If Secondary Insurance, Name of Person Providing Insurance ______________________________

Name of Insurance Company ______________________________

Address ______________________ City ______________ State ________ Zip ________

Phone (   ) ______________________ Group Number ______________________

Referred By ______________________________

The policy in our office is the parent or legal guardian who requests treatment for the child is responsible for all fees for services rendered.
As a service to you, our office will submit charges for services to your insurance company. However, we do consider the patient responsible for the account. When payment of insurance claims is assigned to us, that portion of the fee which is payable by the patient is due at the time of service.

I understand that I am responsible for all charges for services provided. If insurance applies, I understand that I am responsible for any remaining balance unpaid.
I hereby authorize payment of insurance claims to L. Gregory Evans, D.D.S., P.A.

Signature of Parent or Responsible Party ______________________________

Please Complete Reverse Side

Form 180772 Colwell Systems, Champaign, IL

PATIENT MEDICAL HISTORY

Physician______________________________ Office Phone______________

No.	Question		Yes	No
1.	Are you under any medical treatment now?		☐	☐
2.	Have you had any major operations within the past 5 years?		☐	☐
3.	Have you ever had a serious accident involving head injuries?		☐	☐
4.	Have you had any adverse response to any drugs including penicillin? If yes, what? ______________________________		☐	☐
5.	Has a physician ever informed you that you had:	A Heart Ailment?	☐	☐
6.		High Blood Pressure?	☐	☐
7.		Respiratory Disease?	☐	☐
8.		Diabetes?	☐	☐
9.		Rheumatic Fever?	☐	☐
10.		Rheumatism or Arthritis?	☐	☐
11.		Tumors or Growths?	☐	☐
12.		Any Blood Disease	☐	☐
13.		Any Liver Disease?	☐	☐
14.		Any Kidney Disease?	☐	☐
15.		Any Stomach or Intestinal Disease?	☐	☐
16.		Any Venereal Disease?	☐	☐
17.		AIDS?	☐	☐
18.		Yellow Jaundice or Hepatitis?	☐	☐
		Anemia?	☐	☐
		Epilepsy?	☐	☐
19.	Have you ever used Nitrous Oxide (laughing gas)?		☐	☐
20.	Do you prefer to use the Nitrous Oxide?		☐	☐
21.	Are you now taking drugs or medication? If yes, what? ______________________________		☐	☐
23.	Are you in general good health at this time?		☐	☐
24.	Have you any wounds healed slowly or presented other complications?		☐	☐
25.	Are you pregnant?		☐	☐
26.	Do you have a history of fainting?		☐	☐

PATIENT DENTAL HISTORY

No.	Question		Yes	No
28.	Do you have pain in or near your ears?		☐	☐
29.	Do you have any unhealed injuries or inflamed areas in or around your mouth?		☐	☐
30.	Have you experienced any growth or sore spots in your mouth?		☐	☐
31.	Does any part of your mouth hurt when clenched?		☐	☐
32.	Have you ever had Novocaine anesthetic?		☐	☐
33.		Any reactions or allergic symptoms to Novocaine?	☐	☐
34.		Any difficult extractions in the past?	☐	☐
35.		Prolonged bleeding following extractions in the past?	☐	☐
36.		Trench Mouth?	☐	☐
37.	Do your gums bleed?		☐	☐
38.	Have you ever had instructions on the correct method of brushing your teeth?		☐	☐
39.	Have you ever had instructions on the care of your gums?		☐	☐
40.	Do you chew on only one side of your mouth? If so, why?		☐	☐
41.	Do you at the present time have any dental complaints?		☐	☐
42.	Do you habitually clench your teeth during the night or day?		☐	☐
43.	When was your last full mouth X-RAY taken?______________________________			
44.	Any part of your mouth sore to pressures or irritants (colds, sweets, etc.) ______________________________		☐	☐

Signature______________________________