Welcome

ABOUT YOU

Today's Date: _____ E-mail Address: _____

Name: _____ I prefer to be called: _____ ❑ M ❑ F ❑ Non-binary
Last First Mi Mr Mrs Ms Dr

Birthdate: __/__/__ Age: _____ Social Security #: _____ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Address: _____
Street City State Zip

Home Phone #: (____)_____ Cell #: (____)_____ Work Phone #: (____)_____ Ext: ____ Driver License #: _____

Where & 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: ____ Drivers License #: _____

Billing Address: _____
Street City State Zip

SPOUSE INFORMATION

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

Employer: _____ Work Phone #: (____)_____ Ext: ____ Drivers License #: _____

INSURANCE INFORMATION

Primary Insurance Dental Coverage? ❑ Yes ❑ No Medical 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 Birthdate: __/__/__ Relation: _____

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

Secondary Insurance Dental Coverage? ❑ Yes ❑ No Medical 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 Birthdate: __/__/__ Relation: _____

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

CONTINUED ON BACK

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 brush 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: _____ Last Visit Date: _____
(Please Circle)

Why did you leave your previous dentist? _____

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

_____

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

If not, what would you change? _____

_____

MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No Date of last visit: _____

Physician's Name: _____

Address: _____ Phone #: (___) _____

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

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

Have you been vaccinated for Covid-19? ❑ Yes ❑ No
If yes, type? _____ Date(s) _____

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ❑ Yes ❑ No

Have you ever taken Fosamax, or any other Bisphosphonate? ❑ Yes ❑ No

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Sedatives
Y N Barbiturates	Y N Jewelry / Metals	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 Thyroid Medicine
Y N Antibiotics	Y N Blood Thinners	Y N Digitalis/Heart Medication	Y N Recreational Drugs	Y N Tranquilizers
Y N Antihistamines	Y N Blood Pressure Medication	Y N Insulin/Diabetes Drugs	Y N Steroids/Cortisone	

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals 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 Colitis	Y N Headaches	Y N Low Blood Pressure	Y N Shingles
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Heart Attack	Y N Lupus	Y N Sickle Cell Disease
Y N Anemia	Y N Covid-19	Y N Heart Murmur	Y N Mitral Valve Prolapse	Y N Sinus Problems
Y N Arthritis	Y N Diabetes	Y N Heart Surgery	Y N Osteoporosis/Paget's Disease	Y N Steroid Therapy
Y N Artificial Bones/Joints	Y N Difficulty Breathing	Y N Hemophilia		Y N Stroke
Y N Artificial Valves	Y N Drug Abuse	Y N Hepatitis	Y N Pacemaker	Y N Thyroid Problems
Y N Asthma	Y N Emphysema	Y N Herpes	Y N Persistent Cough	Y N Tonsillitis
Y N Autism	Y N Epilepsy	Y N High Blood Pressure	Y N Psychiatric Treatment	Y N Tuberculosis (TB)
Y N Blood Transfusion	Y N Fainting Spells	Y N HIV+/AIDS	Y N Radiation Treatment	Y N Ulcers
Y N Cancer	Y N Fever Blisters	Y N Hospitalized for Any Reason	Y N Rheumatic Fever	Y N Venereal Disease
Y N Chemotherapy	Y N Glaucoma	Y N Kidney Problems	Y N Scarlet Fever	
Y N Chicken Pox	Y N Hay Fever	Y N Liver Disease	Y N Seizures	

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

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

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I certify that I am covered by _____ Insurance Co. 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

Statement of Patient Financial Responsibility

I_____will assume responsibility to pay my portion of services rendered, but I also understand I am responsible for balances not paid by my insurance company. It is the patients responsibility to communicate with their insurance company once the claim has been filed in the event of non-payment by the insurance company. I understand that it is the policy of DR Greg Evans Office to turn all accounts that are 90 days past due over to an outside collection agency. I also understand this will result in a 30% collection fee and Court Costs being added to the account balance.

All outstanding balances are required to be paid prior to additional services, including routine cleanings. I understand that payment is expected in full when service is rendered.

It is the policy of DR Greg Evans office to charge a fee of $50.00 per hour for a missed appointments not cancelled with a 24 hour notice.

Additionally, in the event that I am more that 15 minutes late to my scheduled appointment I understand I may be asked to reschedule for another time or date.

By signing this agreement I acknowledge that I have read the above policy and fully understand and accept its terms

X_____ _____

signature date

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____

Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____

Date: _____

Relationship to patient (if signed by a personal representative of patient):

_____