



PATIENT INFORMATION

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Nickname \_\_\_\_\_  
 Gender \_\_\_\_\_ Marital Status \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Email \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Whom may we thank for referring you to our office? \_\_\_\_\_  
 Notify in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

EMPLOYMENT

Patient's Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Employer Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

INSURANCE

Insured person's name \_\_\_\_\_  
 Relationship to the patient \_\_\_\_\_ Birthdate \_\_\_\_\_ ID# \_\_\_\_\_  
 Address (if different from the patient's) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Insured persons employer \_\_\_\_\_  
 Insurance company \_\_\_\_\_ Group# \_\_\_\_\_  
 Insurance company address \_\_\_\_\_ Phone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

AUTHORIZATION

I authorize and give consent to the performance of the dental services for myself (or my dependent). I give consent to any necessary or advisable dental procedures, medications, or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposes or dental treatment. I understand that using anesthetic agents embodies certain risks.  
 I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for payment of services rendered, regardless of insurance coverage.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



DENTAL HISTORY

Reason for today's visit \_\_\_\_\_

Former dentist \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ Date of last xrays \_\_\_\_\_

Why did you leave? \_\_\_\_\_

How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Do you get frustrated because you always have something that needs to be treated or repaired when you visit the dentist? \_\_\_\_\_

- Check if you have or have had problems with any of the following:
- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> bleeding gums           | <input type="checkbox"/> food collection between teeth    | <input type="checkbox"/> fear                           | <input type="checkbox"/> periodontal treatment      |
| <input type="checkbox"/> clicking or popping jaw | <input type="checkbox"/> grinding teeth                   | <input type="checkbox"/> mouth odors or bad tastes      | <input type="checkbox"/> sensitivity to hot or cold |
| <input type="checkbox"/> orthodontic treatment   | <input type="checkbox"/> cold sores or other oral lesions | <input type="checkbox"/> oral surgery                   | <input type="checkbox"/> sensitivity to sweets      |
|  |   | <input type="checkbox"/> loose teeth or broken fillings | <input type="checkbox"/> sensitivity when biting    |

Are you satisfied with the appearance of your teeth? \_\_\_\_\_

Would you like a whiter smile? \_\_\_\_\_ Would you like straighter teeth? \_\_\_\_\_

Are you deeply concerned about the finances required to return your mouth to excellent dental health? \_\_\_\_\_

WE PROVIDE INDIVIDUALIZED SERVICE FOR OUR PATIENTS.  
TO BETTER YOUR DENTAL HEALTH, PLEASE ANSWER THESE QUESTIONS:

What is most important to you, with us as your dental team? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is most important to you in your dental health? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is most important in your relationship with your dentist? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you could change one thing about your smile, what would it be? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel, Aredia IV, Reclast IV, Zometa IV or any other medications containing bisphosphonates?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No
- Do you use tobacco?  Yes  No
- Do you use controlled substances?  Yes  No

Women: Are you  
Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?  
 Aspirin  Penicillin  Codeine  Local Anesthetics  Acrylic  Metal  Latex  Sulfa drugs  
 Other If yes, please explain: \_\_\_\_\_

- Do you have, or have you had, any of the following?
- |  |  |  |   |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No         | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No        | Hemophilia <input type="radio"/> Yes <input type="radio"/> No            | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No       |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No       | Diabetes <input type="radio"/> Yes <input type="radio"/> No                  | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No           | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No         |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No               | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No            | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No      | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No             |
| Anemia <input type="radio"/> Yes <input type="radio"/> No                    | Easily Winded <input type="radio"/> Yes <input type="radio"/> No             | Herpes <input type="radio"/> Yes <input type="radio"/> No                | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No            |
| Angina <input type="radio"/> Yes <input type="radio"/> No                    | Emphysema <input type="radio"/> Yes <input type="radio"/> No                 | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No   | Rheumatism <input type="radio"/> Yes <input type="radio"/> No                 |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No            | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No      | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No      | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No              |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No    | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No        | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No         | Shingles <input type="radio"/> Yes <input type="radio"/> No                   |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No          | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No          | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No          | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No        |
| Asthma <input type="radio"/> Yes <input type="radio"/> No                    | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No   | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No              |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No             | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No            | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No       | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No               |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No         | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No         | Leukemia <input type="radio"/> Yes <input type="radio"/> No              | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No         | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No        | Liver Disease <input type="radio"/> Yes <input type="radio"/> No         | Stroke <input type="radio"/> Yes <input type="radio"/> No                     |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No             | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No            | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No    | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No          |
| Cancer <input type="radio"/> Yes <input type="radio"/> No                    | Glaucoma <input type="radio"/> Yes <input type="radio"/> No                  | Lung Disease <input type="radio"/> Yes <input type="radio"/> No          | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No            |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No              | Hay Fever <input type="radio"/> Yes <input type="radio"/> No                 | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No                |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No               | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No      | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No          | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No               |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No              | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No    | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No          |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No           | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No   | Ulcers <input type="radio"/> Yes <input type="radio"/> No                     |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No               | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No     | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No      | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No           |
| Cochlear Implants <input type="radio"/> Yes <input type="radio"/> No         | Tattoos/Piercings <input type="radio"/> Yes <input type="radio"/> No         | Protease Inhibitor <input type="radio"/> Yes <input type="radio"/> No    | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No            |
|  |  |  | Sleep Apnea <input type="radio"/> Yes <input type="radio"/> No                |
|  |  |  | STD <input type="radio"/> Yes <input type="radio"/> No                        |

Have you ever had any serious illness not listed above?  Yes  No

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



**DAVID EVANS DDS**  
Cosmetic & General Dentistry

**Acknowledgement of Receipt of Notice of Privacy Practices**

**I acknowledge that I was provided a copy of the Notice of Privacy Practices and have read (or had the opportunity to read if I so choose) and I understood the notice.**

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Patient Name (please print) or Authorized Representative name, if applicable (please print)

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Patient Signature or Authorized Representative Signature

Date

**Office Policies**

PLEASE INITIAL EACH POLICLY AFTER YOU HAVE READ IT

**Cancellation Policy**

Please provide us with at least 24 hours advanced notice if you need to cancel or reschedule an appointment. If we do not receive 24 hours advanced notice you may be charged a \$50.00 cancellation fee.

\_\_\_\_\_ Initials

**Payment Policy**

You are responsible for providing us with your current dental insurance information and for knowing your insurance benefits. If you have provided us with your insurance information, we will bill your insurance company for you. You are responsible for your co-pays and/or deductible and any balance not covered by your insurance. Payment is expected at the time of service. If your account is not paid and it is assigned to a collection service, you will be liable for the collection agency fee of 35% of the unpaid principal balance plus any other collection costs, reasonable attorney fees and court cost.

\_\_\_\_\_ Initials

How would you like to receive billing statements? \_\_\_\_\_ Electronically \_\_\_\_\_ Paper

**Non-Amalgam Use Policy**

Dr. David Evans does not use amalgam restorations for our patients. This decision is not one we take lightly and is based on historical evidence that Amalgam (silver) restorations are inherently inferior to resin (tooth colored) restorations. Your insurance company may not pay for a resin restoration at all or it may reduce your benefit to that of an amalgam filling when the restoration is on a posterior (molar) tooth.

\_\_\_\_\_ Initials

I acknowledge that I have read, understand and agree to the above office policies.

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Patient or Authorized Representative Signature

Date