DAVID EVANS DDS
Cosmetic & General Dentistry

REGISTRATION

PATIENT INFORMATION

First Name _____ Last Name _____ Nickname _____

Preferred pronouns ☐ she/her/hers ☐ he/him/his ☐ they/them/theirs Sex assigned at birth ☐ Male ☐ Female

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 _____

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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.

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

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.

Patient or Authorized Representative Signature Date

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MEDICAL HISTORY

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

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

Comments: _____

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HEALTH HISTORY

DENTAL HISTORY

Reason for todays 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:

- ☐ bleeding gums
- ☐ clicking or popping jaw
- ☐ orthodontic treatment
- ☐ food collection between teeth
- ☐ grinding teeth
- ☐ cold sores or other oral lesions
- ☐ fear
- ☐ mouth odors or bad tastes
- ☐ oral surgery
- ☐ loose teeth or broken fillings
- ☐ periodontal treatment
- ☐ sensitivity to hot or cold
- ☐ sensitivity to sweets
- ☐ 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? _____