DAVID EVANS, DDS
COSMETIC & GENERAL DENTISTRY

REGISTRATION

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

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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?

MEDICAL HISTORY

Are you currently under a physicians care? If so, please explain

Physician's name Phone

Have you had any serious illnesses or operations? If so, please explain

Women: Are you pregnant? If so, how many months? Nursing? Taking birth control pills?

Check if you have taken or have had any of the following:

- anemia
- arthritis/rheumatism
- artificial heart valves
- artificial joints
- asthma
- back problems
- blood transfusion
- cancer/tumors
- chemical dependency
- chemotherapy
- circulatory problems
- cortisone treatments
- cough,persistent
- cough up blood
- diabetes
- epilepsy/seizures
- fainting/dizziness
- headaches
- heart mumur/mitrovalve prolapse
- heart problems
- hemophilia/abnormal bleeding
- herpes
- hepatitis
- high blood pressure
- HIV+/AIDS
- jaw pain
- kidney disease
- liver disease
- osteoporosis medications
- pacemaker/heart surgery
- psychiatric care
- radiation treatment
- rapid weight gain or loss
- respiratory disease
- rheumatic/scarlet fever
- shortness of breath
- sinus problems
- skin rash
- stroke
- swelling of feet/ankles
- thyroid dz
- tobacco habit
- tonsillitis
- tuberculosis
- ulcer
- venereal disease

Do you have or have had any disease, condition or problem not listed above? If so, please explain

List medications you are currently taking

List allergies to any medications or substance

I understand the above information is necessary to provide me with the dental care in a safe and efficient manner. I have answered every question on this form completely and accurately, to the best of my knowledge. I will inform my dentist of any change in my health and/or medication.

Patient Signature Date

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FINANCIAL POLICY

We are commited to support you in understanding your dental health, so that you will always be able to make the best choices. We will, as a courtesy, process your insurance benefits in our office, which will relieve you of this time consuming and sometimes complicated task. In our continued commitment to provide the highest quality dental care available to all our patients and to have those services comfortably affordable, we are pleased to offer you these options for payment.

PLEASE CHECK ONE OF THE FOLLOWING:

☐ PERSONAL CREDIT CARDS

- ☐ MASTERCARD
- ☐ VISA
- ☐ AMERICAN EXPRESS
- ☐ DISCOVER

☐ PRE-PAYMENT

We are happy to offer a 5% discount (3% credit card) for services over $1,000.00 when paid in full upon scheduling your appointment.

☐ CARE-CREDIT

We are pleased to offer multiple financing options which are administered for us by Care-Credit. Please ask our administrative staff for details and credit applications.

I agree that I am fully responsible for the total payment of all procedures performed in this office-- this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that all services are due and payable at the time services are rendered, regardless of whether or not my insurance benefits have been recieived. 1.5% per month interest will be charged on accounts 60 days from treatment date.

MISSED APPOINTMENTS

Appointment times are reserved especially for you. If you come in late, the Doctor may request that you reschedule the appointment and you may be charged a fee of $50. If for any reason you should need to change your appointment, there will be no charge, provided you give us 48 hr notice. Please help us serve you better by keeping your scheduled appointments. We are here to assist you in any way possible. Please make your questions and concerns known to our team. Our goal is to ensure that you have an outstanding experience.

Patient Signature _____ Date _____