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

DAVID EVANS, DDS
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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

David Evans D.D.S.

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 POLICY AFTER YOU HAVE READ IT.

Cancellation Policy

Please provide us with at least 48 hours advanced notice if you need to cancel or reschedule an appointment. If we do not receive 48 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 deductibles 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 any collection fees charged by the agency plus any other collection costs, reasonable attorney fees and court costs.

_____Initials

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