**Patient Information**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ Single \_\_\_ Married (Spouse’s name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_Widowed \_\_\_Divorced

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Position\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Dental Insurance**

Employee/Subscriber Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Insurance Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy I.D.#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Dental Insurance**

Employee/Subscriber Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Insurance Provider :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy I.D.#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

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

Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Circle any of the Following Illnesses You’ve Had or Currently Have:**

AIDS/HIV Frequent Headaches Low Blood Pressure Sleep Apnea

Alzheimer’s/Dementia Heart Murmur Osteoporosis Anxiety/Depression

Anemia Heart problems Pacemaker

Artificial Joint Hepatitis A, B, or C Psychological

Artificial Valve Herpes Simplex Virus Radiation/Chemotherapy

Asthma High Blood Pressure Recurrent Infections

Auto Immune Disease Hyperthyroid Respiratory Problems

Bleeding problems Hypothyroid Seizures

Cancer Inflammatory Rheumatism Stroke

Diabetes Kidney Problems Other Serious Illnesses:

Drug/Alcohol Treatment Liver Problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Circle Any Unusual Reactions/Allergies to the Following Drugs:**

Acetaminophen Erythromycin Sulfa

Aspirin Ibuprofen Sulfites

Codeine Latex Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Anesthetic Penicillin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List All Medications You Are Taking: (including over the counter drugs, herbals & vitamins**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Do you use tobacco? No\_\_\_\_\_\_ Yes\_\_\_\_\_ Type/How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Women: Are you… Pregnant\_\_\_\_\_\_ Nursing\_\_\_\_\_\_\_\_\_\_

Do you have any special instructions from a physician regarding pre-medication for dental work?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything regarding your health that would be important for us to know before starting treatment?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or my child’s) health. It is my responsibility to inform the dental office of any changes in my medical status.**

**Signature of Patient or Parent/Guardian**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Dental Health Evaluation**

1. When was your last dental visit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How often did you see the dentist?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Do any of the following cause you discomfort?

Chewing\_\_\_\_\_\_\_\_ Hot\_\_\_\_\_\_\_\_ Cold\_\_\_\_\_\_\_\_ Sweets\_\_\_\_\_\_

1. How often do you… Brush your teeth?\_\_\_\_\_\_\_\_\_\_

Floss?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rinse/Mouth Wash?\_\_\_\_\_\_\_\_

1. Do your gums bleed while cleaning? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_
2. Do your gums feel tender or swollen? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_
3. Have you had periodontal treatment? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_
4. Do you clench or grind your teeth? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_
5. Does your jaw ever feel tired/ache? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_
6. Does your jaw click or pop? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_
7. Can you chew on both sides of your mouth comfortably? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_
8. Do you have frequent … Headaches? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

Earaches? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

Neck/Shoulder pain? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

1. Have you ever had orthodontic treatment? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

If yes, When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you typically have cavities? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_
2. Do you have loose teeth? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_
3. Do you have noticeable wear on your teeth? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_
4. Do you have any food traps in your teeth? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_
5. Do you have any of the following? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

Fixed bridge

Removable partial Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

Full dentures Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

Implants

1. Do you have any missing teeth? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_
2. Do you lose or break fillings? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_
3. Do you have any cracked or broken teeth? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_
4. Have you ever had an unpleasant dental experience? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

 **Consent to Dental Treatment**

1. I hereby authorize the doctor and designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by the patient and/or legal guardian and to employ such assistance as required in which to provide proper care.
3. I authorize the dentist to release all necessary information to my insurance company to secure payment of benefits.

**(Please initial by each)** **I understand and agree to the following procedures (if necessary):**

 \_\_\_\_\_ Screening/Exam \_\_\_\_\_ Endodontics (Root canal)

 \_\_\_\_\_ Fluoride treatment \_\_\_\_\_ Restorative (Fillings)

 \_\_\_\_\_ Prophylaxis (Cleaning) \_\_\_\_\_ Oral surgery (Tooth removal)

 \_\_\_\_\_ X-rays \_\_\_\_\_ Treatment under Nitrous Oxide

 \_\_\_\_\_ Sealants

**Cancellation/No show policy:**

Scheduled appointments are a contract between the doctor and patient. We understand that it is sometimes necessary to cancel or reschedule appointments, but we ask that you give at least 24 hours’ notice when cancelling or rescheduling. Please call during business hours, as messages left during the weekend will not be considered acceptable advance notice. It is your duty to call if you are running late, and we will do our best to still see you. Evernook Dentistry reserves the right to cancel and/or reschedule patients running more than 15 minutes late. Two appointments cancelled with less than 24 hours’ notice, or a failure to arrive for two scheduled appointments may incur a $50 fee (not billable to insurance). For ProviderOne insurance, two missed appointments will result in termination from the practice.

**Financial Responsibility:**

All payments are due at the time of service unless arrangements have been made and agreed upon by the treating doctor and/or staff. Estimation of insurance benefits is not a guarantee of coverage. It is the patients’ responsibility to understand their insurance benefits and pay their balance regardless of insurance coverage. In the event payments are not received by the agreed upon dates, we will discontinue care until the account is brought current or arrangements have been made. Accounts 90 days past due will be sent to a collection agency.

**I understand the above information and certify that these forms were completed to the best of my knowledge. I understand that is my responsibility to inform Evernook Dentistry staff of any changes to the information I have provided.**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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