EVOLUTION DENTISTRY
Implant, Prosthodontics, Cosmetic, & Reconstructive Dentistry

Date _____

Patient Information (CONFIDENTIAL)

Soc. Sec. # _____

Birthdate _____

Name _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

E-mail: _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married

If Student, Name of School / College _____ City _____ State _____ ☐ Full Time ☐ Part Time

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone: _____

Whom may we thank for referring you? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SSN# _____

Is this person currently a patient in our office? ☐ Yes ☐ No

IT IS THE POLICY OF THIS OFFICE TO MAKE DEFINITE FINANCIAL ARRANGEMENTS BEFORE ANY MAJOR WORK IS STARTED. IN ALL CASES REQUIRING LAB WORK SUCH AS CROWNS, DENTURES, OR BRIDGES WE REQUEST A MINIMUM DOWN PAYMENT OF 50%.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy / ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Insurance Company Phone # _____ How much is your deductible? _____ Max. Annual Benefit _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent if minor)

(Over Please)

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain _____		
3. Are you taking any medication(s) including non-prescription medications?	☐	☐
If yes, what medication(s) are you taking _____		
4. Do you use tobacco?	☐	☐

5. Are you allergic to or have you had any reactions to the following?

	Yes	No
Local Anesthetics (e.g. Novocaine)	☐	☐
Penicillin or any other Antibiotic	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.	☐	☐
Latex Rubber	☐	☐
Other (please list) _____	☐	☐

6. Women Only:
Are you pregnant or think you may be pregnant? ☐ ☐

* For those patients using oral contraceptives: Please be advised that the use of certain antibiotics can reduce the effectiveness of Birth Control. If you have concerns, please speak with the doctor.

Do you have or have you had any of the following?

	Yes	No
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Rheumatic Fever	☐	☐
Swollen Ankles	☐	☐
Fainting / Seizures	☐	☐
Asthma	☐	☐
Low Blood Pressure	☐	☐
Epilepsy / Convulsions	☐	☐
Leukemia	☐	☐
Diabetes	☐	☐
Kidney Diseases	☐	☐
AIDS or HIV Infection	☐	☐
Thyroid Problem	☐	☐
Heart Disease	☐	☐
Cardiac Pacemaker	☐	☐
Heart Murmur	☐	☐
Angina	☐	☐
Frequently Tired	☐	☐
Anemia	☐	☐
Emphysema	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Joint Replacement or Implant	☐	☐
Hepatitis / Jaundice	☐	☐
Sexually Transmitted Disease	☐	☐
Stomach Troubles / Ulcers	☐	☐
Chest Pains	☐	☐
Easily Winded	☐	☐
Stroke	☐	☐
Hay Fever / Allergies	☐	☐
Tuberculosis	☐	☐
Radiation Therapy	☐	☐
Glaucoma	☐	☐
Recent Weight Loss	☐	☐
Liver Disease	☐	☐
Heart Trouble	☐	☐
Respiratory Problems	☐	☐
Mitral Valve Prolapse	☐	☐
Other	☐	☐

Patient Dental History

Reason for todays visit? _____ Last Dental visit (date)? _____
For What Reason? _____ Previous Dentist? _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitve to sweet or sour liquids / foods?	☐	☐
4. Do you feel pain in any of your teeth	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side or face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had prolonged bleeding following extractions?	☐	☐
12. Have you had any orthodontic treatment?	☐	☐
13. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
14. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
15. Do you like your smile?	☐	☐
16. If by magic, you could change anything about your teeth, what would you change? _____		

Additional Comments _____