



Evergreen Hills
DENTAL GROUP

Welcome

PATIENT INFORMATION

Date: _____ SS#: _____

Patient Name _____

LAST NAME

FIRST NAME

MIDDLE

E-mail _____

Address _____

City _____ State _____ Zip _____

Home (____) _____

Work (____) _____ Ext _____

Mobile (____) _____

Sex ☐ M ☐ F Birth date _____ Age _____

☐ Married ☐ Widowed ☐ Single ☐ Divorced

☐ Separated ☐ Partnered ____ years

Former General Dentist _____

Address _____

Phone Number (____) _____

Reason for today's visit _____

Date of Last Dental Checkup _____

Date of Last Dental X-rays _____

Do you have pending treatment? ☐ Yes ☐ No

Patient Employer/School _____

Employer/School Phone _____

Occupation _____

Spouse's Name _____

Spouse's Birthdate _____

Spouse's Employer/School _____

DENTAL INSURANCE

Subscriber's Name _____

Subscriber's Birthdate _____

Relationship to Patient _____

Insurance Co. _____

Member ID# _____

Is patient covered by additional ins? Y / N

Subscriber's Name _____

Subscriber's Birthdate _____

Relationship to Patient _____

Insurance Co _____

Member ID# _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Date

REFERRAL

Whom may we thank for referring you?

☐ Edenvale ☐ Yelp! ☐ Walk-in ☐ Magazine

☐ Web ☐ Other _____

☐ Patient Name _____

DENTAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bad breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Food collection in teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips/mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning on tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen or tender gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chew on one side	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cigarette smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or cheek biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clicking or popping jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth/Broken fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growth in mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fingernail biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Injury to teeth/jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____
Physician's Phone Number (____) _____

Have you ever used a biphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva
☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine) ☐ Yes ☐ No

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial heart valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type ____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen feet/ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormal bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen neck glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor/Growth on head	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital heart lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral valve prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent/bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unexplained weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you wear contact lenses? ☐ Yes ☐ No

Women: Are you pregnant? ☐ Yes ☐ No Due Date _____
Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking:

Pharmacy _____ Ph (____) _____

ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbituates (Sleeping pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex	_____

EMERGENCY CONTACT

IN CASE OF EMERGENCY, CONTACT: (Specify someone who does not live in your household)

Name _____ Relationship _____
Home (____) _____ Work (____) _____ Mobile (____) _____