Welcome to Evens Family Dental - Please Tell Us About Yourself

Name: _____
Last First MI Title

Preferred Name: _____ ❑ Male ❑ Female

Address: _____ City _____ State _____ ZIP _____

SSN: _____ DOB: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail Address: _____

Employer: _____ Occupation: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Domestic Partner

Referred By: _____

Insurance – Primary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Name: _____ Insurance Address: _____

Insurance Company Phone: _____ Group Number: _____

Insurance – Secondary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Name: _____ Insurance Address: _____

Insurance Company Phone: _____ Group Number: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Evens Family Dental 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 hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: _____

Medical History

Name: _____

Are you currently having dental problems? _____

When was your last dental visit? _____

What are your concerns? ***Circle as many as applicable:***

(Pain Avoidance) (Appearance) (Losing Teeth) (Gum/Periodontal Disease) (Cleaning) (Straighter Teeth)

(Cavities) (Oral Cancer) (Wasting / Exceeding Dental Insurance Limits) (Snoring) (Routine Checkup) (General Health)

(Other) _____

Circle yes or no to the following questions:

1. Are you presently under the care of a physician? .. .. Yes No
2. Have you ever had high blood pressure? ..... Yes No
3. Has a physician ever said you have heart trouble? ..... Yes No
4. Do you have Mitral Valve Prolapse? ..... Yes No
5. Have you ever had abnormal bleeding following a cut or extraction? ..... Yes No
6. Do you smoke? _____ How much do you smoke? _____
7. Are you allergic to penicillin, Novocain or any other medication? ..... Yes No
   If so, what? _____
8. Is the patient allergic to anything other than medicine? (e.g. latex or metals)? ..... Yes No
   If so, what? _____
9. Do you require antibiotics before dental treatment? For Mitral Valve Prolapse? Joint Replacement? …… Yes N0

Do you have or ever had:

1. Rheumatic fever? ..... Yes No
2. Rheumatic heart disease? ..... Yes No
3. Anemia, leukemia or low platelets? Yes No
4. Epilepsy or convulsions? ..... Yes No
5. Tuberculosis? ..... Yes No
6. Asthma or hay fever? ..... Yes No
7. Diabetes? How long? ..... Yes No
8. Kidney Trouble? ..... Yes No
9. Liver trouble or jaundice? ..... Yes No
10. Thyroid trouble or goiter? ..... Yes No
11. Syphilis? ..... Yes No
12. Fainting or dizziness? ..... Yes No
13. Glaucoma? ..... Yes No
14. Arthritis? ..... Yes No
15. HIV / AIDS? ..... Yes No
16. Stroke? ..... Yes No
17. Stomach Ulcer? ..... Yes No
18. Heart Murmur? ..... Yes No
19. Prostate Trouble? ..... Yes No
20. Hepatitis? ..... Yes No
21. Eczema or Hives? ..... Yes No
22. Psychiatric Treatment? ..... Yes No
23. Are you pregnant? ..... Yes No

Are you now taking:

1. Drugs for high blood pressure? .....Yes No
2. Drugs for sleep? .....Yes No
3. Cortisone, steroids or ACTH? .....Yes No
4. Anticoagulants or blood thinner? .....Yes No
5. Tranquilizers or sedatives? .....Yes No
6. Antibiotics? .....Yes No
7. Insulin? .....Yes No
8. Others? .....Yes No
9. Have you ever taken Fen-Phen? .....Yes No

LIST MEDICATIONS:_____

_____

Have you ever been under the care of a physician for any major illness or injury other than those noted above? If so, please list:

_____

I hereby authorize the dentist, hygienists and assistants to perform diagnostic, dental and or surgical treatment as recommended.

SIGNATURE:

_____**DATE**:_____

1. Reviewed/changed made on _____Initial: _____
2. Reviewed/changed made on _____Initial: _____
3. Reviewed/changed made on _____Initial: _____

Insurance and Financial Policies

At Evens Family Dental, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

Initials:

_____ ■Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you. We will do our best to maximize your benefits fully.

_____ ■We currently accept most private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you the exact out of pocket figures you may require.

_____ ■We will bill your insurance as a courtesy. If insurance does not pay within 90 days, Evens Family Dental reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

_____ ■Evens Family Dental does require a deposit for restorative and major services. ½ of your portion is due upon scheduling your appointment and the remaining at the time of service. We accept MasterCard, Visa, American Express, Discover, cash, and checks (for existing patients with established payment history). We do not accept checks for over $400.00 for any patient. If you are in need of an extended finance option, we also work with CareCredit, who offers 6, 12 or 18 month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit.

_____ ■A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hour notice.
(Emergencies are an exception).

I agree with the above conditions.

Print Name:_____ Date:_____

Patient/Parent Signature: _____