Evergreen Dental
Dentistry For The Entire Family

PATIENT INFORMATION

Name: First _____ Last _____ ☐ Male ☐ Female

Prefers: _____ Date of Birth: _____

☐ Single ☐ Married ☐ Child ☐ Widowed ☐ Divorced

Cell Phone: _____

Mailing Address: _____ Home Phone: _____

City _____ State _____ Zip _____ Work Phone: _____

Physical Address (if different): _____ SS #: _____

City, State, Zip: _____ Employer: _____

What is the best way to contact you? ☐ Cell ☐ Email ☐ Home ☐ Work ☐ Mail

What is the best way to confirm appointments? ☐ Cell ☐ Email ☐ Home ☐ Work ☐ Mail

Email Address: _____

Who may we THANK for referring you? _____

If child, child lives with? ☐ Both Parents ☐ Mom ☐ Dad Other: _____

Parent/Guardian Information:

Name: _____

Home Address: _____

City, State, Zip: _____

Contact #: _____

DOB: _____ SS #: _____

Spouse or Add'l Parent Information

Name: _____

Home Address: _____

City, State, Zip: _____

Contact #: _____

DOB: _____ SS #: _____

Emergency Contact Info:

Name: _____ Relation: _____

Contact #: _____ Other #: _____

Primary Dental Insurance (or copy card)

Primary Insurance: _____

Address: _____

City, State, Zip: _____

Phone: _____ ID #: _____

Group #: _____

Group Name: _____

Policy Holder: _____

Complete This Section With Or Without The Card

Date of Birth: _____

Relationship To Patient: ☐ Self ☐ Spouse ☐ Child

Policy Holder's Address (if different):

_____

Secondary Dental Insurance (or copy card)

Secondary Insurance: _____

Address: _____

City, State, Zip: _____

Phone: _____ ID #: _____

Group #: _____

Group Name: _____

Policy Holder: _____

Complete This Section With Or Without The Card

Date of Birth: _____

Relationship To Patient: ☐ Self ☐ Spouse ☐ Child

Policy Holder's Address (if different):

_____

Person Filling Out Form: _____

Date: _____

Patient Signature

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MEDICAL HISTORY

Name:_____ **Birthdate:**_____

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

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances?	○ Yes ○ No	If yes
Other?	☐	If yes

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

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Yellow Jaundice	○ Yes ○ No						

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

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FINANCIAL AGREEMENT

Patient Name:_____

Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining health services. If your insurance company rejects a claim and refuses to pay for a service, it is not a reflection of how important the service is. Please note our agreement is with you, NOT your insurance company. If your insurance company refuses to pay or pays less than estimated, you must remember that dental insurance is designed to offset the costs of your dental treatment. You are responsible for the cost of your treatment and any insurance reimbursement conflicts. Our office staff will help you to the best of our ability to obtain your maximum benefits. *We strongly advise you, as our patient, to familiarize yourself with your dental coverage and your benefits.*

We are providing the following payment options, being sensitive to the fact that different people have different needs in fulfilling their financial obligations:

1. We accept Checks, Cash, Money Orders, Visa, MasterCard, Discover and American Express.
2. We offer a 5% discount for treatment paid in full at time of service.
3. We offer 6 month interest-free extended payment plans through Care Credit.
4. We offer an in-office contract with an extended payment plan (up to 3 installments).

PLEASE NOTE: Our office has a 24 hour cancellation policy. Your appointment is time reserved especially for you as our patient to provide you with outstanding care for your dental needs. We strive to provide you with a one day courtesy reminder via email, text or phone call. However, it is ultimately your responsibility to remember your dental appointment. Please take note that there is a "No Show" fee of **$50.00** charged for appointments that are not canceled or rescheduled.

To avoid increased fees to all patients, any account balance over 30 days will be assessed a fee of 18% of the balance due. All accounts over 90 days will be notified in writing of their account being transferred to a collection agency.

Patient's Signature_____

Date:_____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

* Obtain payment from third-party payers.

* Conduct normal healthcare operations such as quality assessments and doctor certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Evergreen Dental has the right to change its Notice of Privacy Practice from time to time and that I may contact them at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Name (Printed): _____

Parent Name (if minor): _____

Relationship to Patient: ( ) Self ( ) Parent ( ) Other: _____

Signature: _____ Date: _____

I would like to give the following individuals authorization to discuss matters relating to my treatment and account. I understand that without this consent, no one, other than myself, will be able to discuss these matters. This authorization remains in effect until withdrawn by you in writing.

_____ Relationship to Patient: ( ) Spouse ( ) Parent ( ) Other: _____

_____ Relationship to Patient: ( ) Spouse ( ) Parent ( ) Other: _____

OFFICE USE ONLY

I attempted to obtain the patient's or legally authorized individual's signature on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____