PATIENT REGISTRATION

Welcome!

Thank you for completing this confidential information to help us better serve your dental needs.

Date _____

PATIENT INFORMATION

Name _____
FIRST | MIDDLE | LAST | NICKNAME

Phone _____
HOME | WORK | CELL | EMAIL

Address _____
STREET | CITY | STATE | ZIP CODE

Other _____
DATE OF BIRTH | SOCIAL SECURITY | MARITAL STATUS | OCCUPATION

RESPONSIBLE PARTY INFORMATION

Name _____
FIRST | MIDDLE | LAST | RELATION TO PATIENT

Phone _____
HOME | WORK | CELL | EMAIL

Address _____
STREET | CITY | STATE | ZIP CODE

Other _____
DATE OF BIRTH | SOCIAL SECURITY | MARITAL STATUS | OCCUPATION

DENTAL INSURANCE INFORMATION

Primary _____
INSURANCE COMPANY NAME | **GROUP NUMBER** | **Individual Policy Holder ID**

Insured _____
FIRST | MIDDLE | LAST | RELATION TO PATIENT

Insured _____
DATE OF BIRTH | SOCIAL SECURITY | MARITAL STATUS | OCCUPATION

Employer _____
EMPLOYER'S NAME | DATE EMPLOYED

Secondary _____
INSURANCE COMPANY NAME | GROUP NUMBER

Insured _____
FIRST | MIDDLE | LAST | RELATION TO PATIENT

Insured _____
DATE OF BIRTH | SOCIAL SECURITY | MARITAL STATUS | OCCUPATION

Employer _____
EMPLOYER'S NAME | DATE EMPLOYED

Who may we thank for referring you to our office? _____

In case of emergency, contact: _____
NAME | PHONE | RELATION TO PATIENT

CONSENT, ASSIGNMENT OF BENEFITS AND RESPONSIBILITY

I hereby authorize and request the performance of dental services for myself (or child). I also give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or the supervised staff. I hereby authorize this office to furnish information to insurance carriers concerning any treatment and I assign to the dentist all payments for dental services rendered to myself or my dependents. I understand that I am financially responsible for the services provided, regardless of insurance coverage and that payment is due and payable at the time services are rendered unless financial arrangements have been made. In the event of default, I promise to pay legal interest on the indebtedness together with collections costs and reasonable attorney fee.

_____ _____
PATIENT OR GUARDIAN'S SIGNATURE | DATE

Your dental health relates to our overall health. Medical problems or medications could affect your teeth and gums. So that we may treat you holistically, please complete the following confidential information.

MEDICAL HISTORY

If you had a magic wand and could change anything about your smile, what would it be?

_____

Do you wish to whiten your teeth?

_____

DATE _____

NAME _____ LAST PHYSICAL _____

PHYSICIAN _____ PHYSICIAN'S PHONE _____

NO YES

- ☐☐ Are you currently under a physician's care? _____
- ☐☐ Do you require antibiotic premedication prior to dental treatment? _____
- ☐☐ Do you have any alcohol or drug related problems? _____
- ☐☐ Do you smoke or chew tobacco? How much? _____
- ☐☐ Do you presently or have you ever taken medication for osteoporosis? (e.g. Fosamax)
- ☐☐ Are you currently taking medications? List name and dosage.

_____

- ☐☐ Do you have any diseases, conditions or problems not mentioned? Explain.

_____

ALLERGIC REACTIONS	NO	YES
Analgesics	☐	☐
Anesthetics	☐	☐
Antibiotics	☐	☐
Latex	☐	☐
Sulfa Drugs	☐	☐
Other_____	☐	☐

CARDIOVASCULAR	NO	YES
Angina Pectoris	☐	☐
Artificial Heart Valve	☐	☐
Congenital Heart Disease	☐	☐
Fainting or Dizzy Spells	☐	☐
Heart Murmur	☐	☐
Heart Trouble	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Mitral Valve Prolapse	☐	☐
Pacemaker	☐	☐
Rheumatic Fever	☐	☐
Stroke	☐	☐
Swollen Ankles	☐	☐

ENDOCRINE	NO	YES
Diabetes	☐	☐
Thyroid Problems	☐	☐

GENITOURINARY	NO	YES
Bladder Trouble	☐	☐
Kidney Trouble	☐	☐
Venereal Disease	☐	☐

MUSCULOSKETAL	NO	YES
Arthritis / Rheumatism	☐	☐
Back Problems	☐	☐

GASTROINTESTINAL	NO	YES
Hepatitis A / B / C	☐	☐
Liver Disease or Jaundice	☐	☐
Ulcers	☐	☐
Weight Loss or Gain	☐	☐

RESPIRATORY	NO	YES
Allergies or Hives	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Emphysema	☐	☐
Hay Fever	☐	☐
Pneumonia	☐	☐
Sinus Trouble	☐	☐
Tuberculosis	☐	☐

NEUROLOGIC	NO	YES
Anxiety Problems	☐	☐
Epilepsy or Seizures	☐	☐
Parkinson's Disease	☐	☐
Psychiatric Care	☐	☐

HEMATOLOGIC	NO	YES
Blood Transfusions	☐	☐
Bruise or Bleed Easily	☐	☐
Hemophilia	☐	☐
Leukemia	☐	☐
Sickle Cell Anemia	☐	☐

IMMUNOLOGIC	NO	YES
AIDS	☐	☐
HIV Positive	☐	☐
Night Sweats	☐	☐
Skin Disease	☐	☐

SPECIAL SENSES	NO	YES
Contact Lenses	☐	☐
Ear Problems	☐	☐
Eye Problems	☐	☐
Smell or Taste Problems	☐	☐

SURGERY	NO	YES
Artificial Joints	☐	☐
Cancer or Tumors	☐	☐
Chemotherapy	☐	☐
Operation in Past 5 Years	☐	☐
Organ Transplant	☐	☐
Radiation Therapy	☐	☐

WOMEN	NO	YES
Birth Control Pills	☐	☐
Nursing	☐	☐
Pregnant or Lactating	☐	☐

FACIAL PAIN HISTORY	NO	YES
Facial or Neck Pain	☐	☐
Headaches or Migraines	☐	☐
Jaw Noise or Pain	☐	☐
Pain upon Chewing	☐	☐
Injury to Head or Neck	☐	☐

I accurately answered these questions. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you.

PATIENTS'S SIGNATURE

DOCTOR'S SIGNATURE

Patient Responsibility and Receipt of Privacy Practices Form

X Patient Name:_____Date:_____

We are pleased to assist you with your dental insurance. If you have dental insurance, please be aware that insurance quotes are an ESTIMATE only. Coverage may be different if your deductible has not been met, annual maximum has been met, or if your coverage table is lower than average.

Co-pays:
I understand that I am responsible to pay all co-payment at the time of service, prior to leaving.

Deductible:
If my insurance determines that I have not met my deductible I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by insurance and/or provider.

I acknowledge that I assume full financial responsibility for services rendered to me, if my insurance carrier denies or does not cover my claim for these services. I understand the terms of this form and accept financial responsibility with or without the use of insurance coverage.

Missed Appointment Fee:
We respect your time, please respect ours by giving 24 hours notice if unable to make your appointment so that we can help other patients. A $50 missed appointment fee will be charged if within 24 hours.

Privacy Practices: Acknowledge of Receipt of Privacy Practices Notice.

X I, _____, acknowledge that I have recieved a Notice, or been given an opportunity to review the Privacy Practices regarding my patient care at Evolve Dental Care.

X _____

Patient Signature/Guardian Date

Good Faith Effort to Obtain Acknowledgement of Receipt.
Describe the good faith effort to obtain the individual's signature and the reason for the individual not signing the form:

_____
_____
_____
_____

Employee SIGNATURE:
I attest the above information is correct.

Signature: _____ Date: _____

COVID-19 Pandemic Emergency Dental Treatment

Notice and Acknowledgement of Risk Form

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures create water spray which is one way the disease is spread. The ultra-fine nature of the water spray can linger in the air for a long time, allowing for transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask over your mouth to prevent infection during treatment as your health care providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

Pursuant to statements from the Center for Disease Control (CDC) and the American Dental Association (ADA), non-essential or elective treatment, based on the assessment of our staff, will be rescheduled. According to the ADA, dental emergencies are "potentially life threatening and require immediate treatment to stop ongoing tissue bleeding [or to] alleviate severe pain or infection." The ADA also recommends that urgent dental care which "focuses on the management of conditions that require immediate attention to relieve severe pain and/or risk of infection and to alleviate the burden on hospital emergency departments" be provided in as minimally invasive a manner as possible.

I confirm that I have read the Notice above and understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office or with dental treatment. I further confirm I am seeking treatment for a condition that meets the emergent or urgent criteria noted above. I understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit here.

I have read and understand the information stated above:

_____ _____

Signature Date

_____

Witness