

Main St. Dental

Dr. Carol Evans

Date: _____

Patient Information

Patient Name: _____ Date of Birth: _____ Age _____
 Preferred Name: _____ Social Security #: _____
 Patient Address: _____ Driver's License #: _____
 City/State/Zip: _____ Employer: _____
 Home Phone: _____ Married ___ Single ___ Child ___
 Work Phone: _____ Female ___ Male ___
 Cell Phone: _____

Referral Information

How did you learn about our practice?
 ___Advertisement ___Web Search ___Yellow Pages
 Who may we thank for referring you? _____

*Please indicate your preference for contact: email or phone (circle one). E-mail: _____
 In case of emergency: Name _____ Phone _____
 Relationship _____

Medical History

Have you had any of the following? Please check those that apply:

Heart Problems		Chemical Dependency		Cortisone Treatment	
High Blood Pressure		Cancer / Radiation Therapy		HIV / AIDS	
Heart Murmur		Chemotherapy		Hearing Impaired	
Artificial Heart Valves		Thyroid Problems		Artificial Joints	
Rheumatic Fever		Respiratory Problems		Allergies	
Diabetes		Asthma		Osteoperosis	
Hepatitis Type _____		Pacemaker		Pregnant / Nursing	
Tobacco Use		Fainting / Epilepsy		Nervous Problems	

Are you allergic to any drugs? _____
 Are you allergic to latex? _____
 Are you taking blood thinners? _____
 Are you currently under the care of a physician? _____
 If yes, please explain: _____
 Do you have any health problems that need further clarifications? _____
 If yes, please explain: _____
 Have you been hospitalized for any surgery or serious illness within the last 5 years?
 If yes, please explain: _____
 List medications you are currently taking: _____

Dental History

Previous Dentist: _____

City: _____

Date of last dental visit: _____

Date of last dental x-rays: _____

Reason for that visit: _____

Do you have a history of: Please check those that apply:

Gum Disease	<input type="checkbox"/>	Difficult Extractions	<input type="checkbox"/>	Mouth / sores or swelling	<input type="checkbox"/>
Bleeding Gums	<input type="checkbox"/>	Grinding Teeth	<input type="checkbox"/>	Clicking or Popping Jaw	<input type="checkbox"/>
Sensitivities - cold / sweets / biting	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>

Have you ever been told that you require an Antibiotic pre-medication? _____

Smile Evaluation

The greatest service we provide to our patients is to give them a well-designed plan for accomplishing their dental goals. By answering the following questions, you can help us understand you and your goals and enable us to give you our very best.

Is there anything you don't like about your smile or that concerns you about your mouth? **YES or NO**

If yes, please explain _____

Do you have any old fillings or dental work you don't like? **YES or NO**

Are you nervous about dental treatment? (Please circle below)

Extremely Somewhat Not At All Love The Dentist

Do you want whiter teeth? **YES or NO** Do you want to keep your teeth a lifetime? **YES or NO**

PLEASE LIST ANY HOBBIES OR INTERESTS YOU HAVE: _____

Consent for Services

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at time of visit. Patient is solely responsible for any balance not paid by their insurance company. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize Main St. Dental to release any information to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

We may contact you through email.

Signature: _____ Date: _____

Updates: _____