PAUL L. EVANS, D.D.S.

MERCURY-FREE COMPREHENSIVE DENTISTRY

Birthdate _____ Today's Date _____

Patient's Name _____ Nickname _____
Last First Middle Initial

Mailing address _____
City State Zip Code

Street Address _____

Social Security # _____ Drivers License # _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ Marital Status _____

How would you like us to confirm your appointments? ☐ Text ☐ Email ☐ Phone

Occupation _____ Employer _____

Name of Spouse _____ Spouse's Social Security # _____

Spouse's Employer _____ Phone _____

Person Responsible for Account _____ Relationship _____

Referred to us by _____

In case of emergency, nearest relative (other than spouse) _____ Phone _____

Nearest Friend _____ Phone _____

How will you be paying for the dental service performed? Cash ☐ Check ☐ Charge Card ☐ Insurance ☐

DENTAL QUESTIONNAIRE

Regarding your first visit in our dental office:

Please state your reason for coming to our office: _____

Are you in pain or having other major problems at this time? Yes ☐ No ☐

If yes, please list _____

_____

How long has it been since your last dental visit? _____ Previous dentist _____

Address/Phone _____

Do you feel especially nervous or fearful about dental treatment? Yes ☐ No ☐

If yes, please explain: _____

Have you ever had any serious problem or upsetting experience in a dental office? Yes ☐ No ☐

What is the reason for leaving your last dental office? _____

_____

_____

HEALTH QUESTIONNAIRE

In order for us to provide you with the best possible care, please answer the following questions completely. This information will allow us to treat you on an individual basis, appropriate to your particular needs. If any question is not understood, it should be discussed with the doctor. All answers will be confidential.

Physician's Name _____ Phone _____

Address _____ Last Visit _____

Date of last physical exam _____ Significant findings _____

_____

continued on back

563 Brunswick Road • Suite 1 • Grass Valley CA 95945 • (530) 273-4442

QUESTIONNAIRE CONTINUED

Your general health is: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Has there been a change in your health in the past year? Yes ☐ No ☐ If yes, please explain: _____

_____

Are you now taking any medications, drugs or pills? Yes ☐ No ☐ If yes, please list: _____

_____

Place a mark on "yes" or "no", if you have had an adverse reaction to the following:

	Yes	No		Yes	No		Yes	No		Yes	No
Penicillin	☐	☐	Sedatives	☐	☐	Antihistamines	☐	☐	Ibuprophen (Advil)	☐	☐
Tetracycline	☐	☐	Local Anesthetic	☐	☐	Aspirin	☐	☐	Hydrocodone (Vicodin)	☐	☐
Erythromycin	☐	☐	Nitrous Oxide	☐	☐	Codeine	☐	☐	Other Pain Reliever	☐	☐
Other Antibiotic	☐	☐	Sulfa	☐	☐	Acetominophen			Metal	☐	☐
Keflex	☐	☐				(Tylenol)	☐	☐			

Are you aware of being allergic to any other medication or substance? Yes ☐ No ☐

If yes, please list: _____

Place a mark on "yes" or "no", if you have had any of the following:

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease	☐	☐	Ulcers or colitus	☐	☐	Hepatitis/Liver disease	☐	☐	AIDS/Arc/HIV+	☐	☐
Abnormal Blood Pressure	☐	☐	Lung problems/Asthma	☐	☐	Abnormal Bleeding	☐	☐	Blood Transfusion	☐	☐
Scarlet fever	☐	☐	Fever blisters/cold sores	☐	☐	Alcoholism	☐	☐	Joint Replacement	☐	☐
Congenital Heart Disease	☐	☐	Arthritis	☐	☐	Drug Addiction	☐	☐	Hives or Allergy	☐	☐
Heart Murmur	☐	☐	Diabetes	☐	☐	Rheumatism	☐	☐	Seizures	☐	☐
Stroke	☐	☐	Thyroid Problems	☐	☐	Pacemaker	☐	☐	Fainting or Dizziness	☐	☐
Kidney Disease	☐	☐	Tumor or Cancer	☐	☐	Anemia	☐	☐			
Heart Surgery	☐	☐	Tobacco/Smoking	☐	☐						

Have you ever been advised to take antibiotics preventively before dental treatment? Yes ☐ No ☐

If yes, why? _____

_____

Do you, or have you in the past, taken any medication for the prevention or treatment of Osteoperosis or Paget's Disease such as Fosamax, Boniva or any other biphosphonates. Yes ☐ No ☐

If yes, please list _____

_____

Do you have, or have you had, any disease, condition, or problem not listed above that you think we should know about?

Yes ☐ No ☐

If yes, please explain _____

_____

WOMEN: Are you pregnant? Yes ☐ No ☐ If yes, what month?_____ Are you nursing? Yes ☐ No ☐

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that 1 1/2% service charge (18% annually) will be added to any balance over 30 days. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this debt. Should I request credit for dental treatment, I consent to a credit check if deemed necessary.

Patient's Signature _____ Date _____

Patient or Responsible Party_____ Relationship _____