Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Patient Information (CONFIDENTIAL)

Date_____

Name_____ Birth date_____ Soc. Sec. #_____

Address_____City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ E-Mail Address_____

Preferred Name To Be Addressed By: _____
Check Appropriate Boxes: ☐Mr.☐Mrs.☐Ms.☐Miss☐Dr. ☐Minor☐Single☐Married☐Widowed☐Separated

If Student, Name of School_____ City_____ State_____ ☐Full time ☐Part time

If patient is a minor, give parent's or guardian's name _____

How Did You Learn About Us? ☐Phone book ☐Office Sign ☐Referred by:_____
☐Received Welcome Letter ☐Newspaper Ad ☐Other (Please Specify)_____

Responsible Party

Name of Person Responsible for this Account_____

Check Appropriate Boxes: ☐Mr.☐Mrs.☐Ms.☐Miss☐Dr. ☐Minor☐Single☐Married☐Widowed☐Separated

Residence _____City_____ State _____Zip_____

Mailing Address_____ City_____ State_____ Zip_____

How long at this address? _____ Home Phone_____ Work Phone _____

Previous Address (if less than 3 yrs.) _____

Soc. Sec. #_____ Birth Date_____ Relationship to Patient_____

Employer_____Occupation_____ No. Years Employed _____

Spouse's Name_____ Relationship to Patient_____

Employer_____Occupation_____ No. Years Employed _____

Soc. Sec. #_____ Birth Date_____ Work Phone_____

Is this Responsible Party Currently a Patient in our Office? ☐Yes ☐No
Do we have your permission to contact you at work during the day? ☐Yes ☐No

Emergency Information

Name of nearest relative not living with you _____Phone_____

Complete Address _____

Dental Insurance Information

Name of Insured_____ Birth Date_____ Soc. Sec. #_____

Name of Employer_____ Union or Local #_____ Work Phone_____

Address of Employer_____ City_____ State_____ Zip_____

Insurance Company_____ Group #_____ Policy / ID #_____

Ins. Co. Address_____ City_____ State_____ Zip_____

Do you have secondary Dental Insurance? If yes, complete the following:

Name of Insured_____ Birth Date_____ Soc. Sec. #_____

Name of Employer_____ Union or Local #_____ Work Phone_____

Address of Employer_____ City_____ State_____ Zip_____

Insurance Company_____ Group #_____ Policy / ID #_____

Ins. Co. Address_____ City_____ State_____ Zip_____

Authorizations, Agreements and Consent

Please initial items you authorize and understand, then sign at the bottom

☐ Authorization and Consent for Dental Treatment of Minor

I being the parent, guardian, or other person entitled to legal custody of _____, a minor child, do hereby authorize and consent to x-rays, examination, anesthetic or dental treatment to be rendered to said minor child under the general or direct supervision of Richard B. Evans, D.D.S. as the dentist may deem necessary.

☐ Authorization for Release of Information and Assignment of Benefits

I authorize release of any information relating to any insurance claim. I understand that I am responsible for all costs of Dental Treatment even if it is covered by dental insurance. I also authorize payment of dental benefits, otherwise payable to me, directly to Richard B. Evans, D.D.S., Inc.

☐ Authorization for Release of Medical and Dental Information

I authorize release of any information relating to any dental or medical consultation.

☐ Photographic Consent

I consent to photographs being taken. I understand they may be used for documentation and educational purposes.

☐ Interest on Unpaid Balances

I understand that a monthly charge of 1½% per month (18% per year) will be added on all accounts not paid within 60 days; and, where appropriate, credit bureau reports may be obtained.

☐ Appointments

Appointments are exclusively scheduled for you. We do not schedule more than one patient at a time with the doctor or hygienist. Sometimes unexpected things occur which cause us to run behind. If we run more than 15 minutes behind we will give you the option of rescheduling. Broken appointments are a loss to everyone. **A notice of 48 hours is required if you are unable to keep an appointment; otherwise, we reserve the right to charge a broken appointment fee of $50.**

Signature (Parent's signature if minor)_____ Date_____

Updates (date & initial) _____ _____ _____ _____ _____

Submit