



Edwards
Everhart
Dental

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.

Soc. Sec. # _____

Date _____

Cell Phone _____

Home Phone _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Email Address _____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

If Patient is a Student, Name of School / College _____ City _____ State _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No

IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

1. Are you under medical treatment now?.....☐ Yes ☐ No

2. Have you ever been hospitalized for any surgical operation or serious illness?.....☐ Yes ☐ No

3. Are you taking any medication(s) including non-prescription medicine?.....☐ Yes ☐ No
If yes, what medication(s) are you taking? _____

4. Do you use tobacco?.....☐ Yes ☐ No

5. Do you use alcohol, cocaine or other drugs?.....☐ Yes ☐ No

6. Are you wearing contact lenses?.....☐ Yes ☐ No

7. History of Pre-Med?.....☐ Yes ☐ No

8. Are you allergic to or have you had any reactions to the following?.....☐ Yes ☐ No
Local Anesthetics (eg. novocaine).....☐ Yes ☐ No
Penicillin or other Antibiotics.....☐ Yes ☐ No
Sulfa Drugs.....☐ Yes ☐ No
Latex Allergy.....☐ Yes ☐ No
Sedatives.....☐ Yes ☐ No
Iodine.....☐ Yes ☐ No
Aspirin.....☐ Yes ☐ No
Other.....☐ Yes ☐ No

9. Women Only:
a) Are you pregnant or think you may be pregnant?.....☐ Yes ☐ No
b) Are you nursing?.....☐ Yes ☐ No
c) Are you taking birth control pills?.....☐ Yes ☐ No

10. Do you have or have you had any of the following?

Yes No

High Blood Pressure.....☐ Yes ☐ No

Heart Attack.....☐ Yes ☐ No

Rheumatic Fever.....☐ Yes ☐ No

Swollen Ankles.....☐ Yes ☐ No

Fainting/Seizures.....☐ Yes ☐ No

Asthma.....☐ Yes ☐ No

Low Blood Pressure.....☐ Yes ☐ No

Epilepsy/Convulsions.....☐ Yes ☐ No

Leukemia.....☐ Yes ☐ No

Diabetes.....☐ Yes ☐ No

Kidney Diseases.....☐ Yes ☐ No

AIDS or HIV Infection.....☐ Yes ☐ No

Thyroid Problem.....☐ Yes ☐ No

Yes No

Heart Disease.....☐ Yes ☐ No

Cardiac Pacemaker.....☐ Yes ☐ No

Heart Murmur.....☐ Yes ☐ No

Angina.....☐ Yes ☐ No

Frequently Tired.....☐ Yes ☐ No

Anemia.....☐ Yes ☐ No

Emphysema.....☐ Yes ☐ No

Cancer.....☐ Yes ☐ No

Arthritis.....☐ Yes ☐ No

Joint Replacement or Implant.....☐ Yes ☐ No

Hepatitis/Jaundice.....☐ Yes ☐ No

Sexually Transmitted Disease.....☐ Yes ☐ No

Stomach Troubles / Ulcers.....☐ Yes ☐ No

Yes No

Chest Pains.....☐ Yes ☐ No

Easily Winded.....☐ Yes ☐ No

Stroke.....☐ Yes ☐ No

Hay Fever / Allergies.....☐ Yes ☐ No

Tuberculosis.....☐ Yes ☐ No

Radiation Therapy.....☐ Yes ☐ No

Glaucoma.....☐ Yes ☐ No

Recent Weight Loss.....☐ Yes ☐ No

Liver Disease.....☐ Yes ☐ No

Heart Trouble.....☐ Yes ☐ No

Respiratory Problems.....☐ Yes ☐ No

Other.....☐ Yes ☐ No

Patient Dental History

1. Do your gums bleed while brushing or flossing?.....☐ Yes ☐ No

2. Are your teeth sensitive to hot or cold liquids/foods?.....☐ Yes ☐ No

3. Are your teeth sensitive to sweet or sour liquids/foods?.....☐ Yes ☐ No

4. Do you feel pain to any of your teeth?.....☐ Yes ☐ No

5. Do you have any sores or lumps in or near your mouth?.....☐ Yes ☐ No

6. Have you had any head, neck or jaw injuries?.....☐ Yes ☐ No

7. Have you ever experienced any of the following problems in your jaw?
a) Clicking?.....☐ Yes ☐ No
b) Pain (joint, ear, side of face)?.....☐ Yes ☐ No
c) Difficulty in opening or closing?.....☐ Yes ☐ No
d) Difficulty in chewing?.....☐ Yes ☐ No

8. Do you have frequent headaches?.....☐ Yes ☐ No

9. Do you clench or grind your teeth?.....☐ Yes ☐ No

10. Do you bite your lips or cheeks frequently?.....☐ Yes ☐ No

11. Have you ever had any difficult extractions in the past?.....☐ Yes ☐ No

12. Have you had any orthodontic work?.....☐ Yes ☐ No

13. Have you ever had any prolonged bleeding following extractions?.....☐ Yes ☐ No

14. Have you ever had instruction on the correct method of brushing your teeth?.....☐ Yes ☐ No

15. Have you ever had instructions on the care of your gums?.....☐ Yes ☐ No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

Signature of patient or parent if minor

Doctor's Comments

Signature

Date



Edwards Everhart Dental

Directions

Highway 50,
Exit Latrobe Road,
Right on Golden Foothill Parkway (Business Park 3),
Left on Sandstone Drive,
Immediate right into our parking area,
We are on the corner of Sandstone & Golden Foothill
Parkway.

Fees and payment policy

- Payment is expected at each appointment.
- After final insurance payment, any remaining balance is due in full upon receipt of your statement.
- All major credit cards accepted.
- Extended payments are available upon special request.
- Accounts outstanding more than 60 days are referred to an outside receivables service for collection.
- We offer our senior citizens several discount options, please ask for more details.

Dental Insurance

Your insurance contract is between you and your insurance company. The type of benefits in your contract depends on what your employer has negotiated. We ask that you provide correct and updated information each time you have an appointment. As a courtesy, we will complete your dental claim form and forward it to your insurance carrier. We ask that you assign your insurance benefits to us. Our staff makes every effort to collect current and accurate information about your benefits prior to treatment so we may accurately estimate your amount due. Knowing about your benefits is your responsibility. Payment of any treatment not covered for any reason is the patient's responsibility.

Appointment Cancellations

Attended, well-planned appointments usually mean fewer trips to our office. It is very important that you understand that this is time set aside especially for you and that appointments should be scheduled for times when they can definitely be kept. As a courtesy, our office will make two attempts to confirm appointments although it is the patient's responsibility to make note of the appointments.

A missed appointment is a loss to everyone. Please call and reschedule as soon as possible so that time may be offered to another patient. There will be a \$50.00 charge for broken or failed appointments without 48 hours notice.

