EVERGREEN
DENTAL CARE

Office Phone Number: 480-831-6640
Email to: info@evergreen-dentalcare.com

Patient Information Update:

Patient Name: _____

Preferred Name: _____

Title (Mr./Mrs./Dr./etc): _____

Gender: **Male ____ Female ____**

Family Status: **Married ____ Single ____ Child ____ Other ____**

Birthdate: _____ Social Security Number: _____

Email Address: _____ Phone Number: _____

Address:_____

City:_____ State:_____ Zip: _____

Insurance Information

Do you have dental insurance? **Yes ____ No ____**

If not, ask us about our in-house dental plan.

Name of Insured: _____

Patient's relationship to insured: **Self ____ Spouse ____ Child ____ Other ____**

Insured's Birthdate: _____

ID Number: _____ Group Number: _____

Insurance Plan Name: _____ Insured's Social Security Number: _____

Insured's Employer Name: _____

Health History Update:

Patient Name: _____

Within the past year, have there been any changes to your general health? **Yes ____ No ____**

If yes, please explain:

_____

_____

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Health History Update Continued:

Primary Care Physician's Name and phone Number:

_____

Please List Medications:

_____

_____

Women Only: Are you pregnant? **Yes ____ No____**

If yes, when is your due date? _____

Are you currently undergoing IVF Treatment? **Yes ____ No ____**

Please circle all that apply to you:

Allergies	Blood Thinners	Liver Disease
Latex Allergy	Fainting	Mental Disorders
Codeine Allergy	Head Injuries	Nervous Disorders
Penicillin Allergy	History of Stroke	Pacemaker
Artificial Joints	History of Heart Attack	Radiation Treatment
Asthma	Heart Disease or Ailments	Chemotherapy
Blood Disease	Heart Murmur	Respiratory Problems
Cancer	Hepatitis	Sinus Problems
Diabetes (Type 1 or Type 2)	HIV	Migraines
Dizziness	High Blood Pressure	Stomach Problems
Epilepsy	Kidney Disease	Tobacco Use

Please elaborate further on above circled conditions:

_____

_____

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Any other health issues or allergies not noted above?

_____

_____

Dental History Update:

Do you have any concerns today?

_____

_____

Do you have or wear a night guard? **Yes ____ No ____**

Do you have or wear retainers? **Yes ____ No ____**

Would you be interested in having straighter Teeth? **Yes ____ No ____**

Have we ever discussed the possibility of gum disease or infection in the gum tissue in the past?

Yes ____ No ____ Unsure ____

Please circle all that apply today:

Broken Teeth	Bleeding Gums	Bad Breath or Odor
Food Catching	Crooked Teeth	Sores or Growths in Mouth
Sensitivity to Biting	Chipped Teeth	Grinding/Clenching
Sensitivity to Hot/Cold	Sensitive to Sweets	Vape/Tobacco Usage

Any Other Dental Concerns

_____

How would you rate your dental anxiety/fear? (1 = none, 10 = greatest fear)

1 2 3 4 5 6 7 8 9 10

To help with your comfort, are you interested in any of the following?

Headphones/Music ____ Blanket/Pillow ____ Oral Sedation Medication ____ Nitrous Gas ____

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GENERAL INFORMED CONSENT

I hereby authorize Drs. John Lopez and William Blocher, to take the necessary X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Drs. John Lopez and William Blocher to make a thorough diagnosis of the patient's dental needs. I also authorize Drs. John Lopez & Wm Blocher, to perform all forms of treatment, medication, and therapy that may be indicated. I also understand that the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier and not between Drs. John Lopez and William Blocher, and your insurance company. I fully understand that it is my financial responsibility for all dental treatment, regardless of insurance coverage.

HIPAA PRIVACY FORM

*Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices (found in our office) or to document our good faith effort to obtain that acknowledgment may refuse to sign this acknowledgment***

I, _____, have received a copy OR read the explanation of this office's Notice of Privacy Practices.

_____ {Date}_____

{Signature of Patient and/or Guardian}

{Relationship to Patient} **Self** ____ **Othe**r: _____

I, _____, acknowledge and allow Drs. John Lopez and William Blocher, to share my information with the following people, besides those already stated within the Notice of Privacy Practices.

( ) I authorize the release of information, including the diagnosis, records, and examination rendered to me, and claims information. This information may be released to:
( ) Spouse _____
( ) Child(ren) _____
( ) Other _____
( ) No information is to be released to anyone.

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This **Release of Information** will remain in effect until terminated by me in writing.

The best time to reach me personally is (day) _____ between (time) _____

Please call my cell number: _____ My work number: _____

If unable to reach me: ( ) you may leave a detailed message ( ) Permission to Text/email me.

Signed: _____ Date: ____/____/_____