Evanston Dental Care

Patient Information

Date: _____/_____/_____

Last Name: _____ First Name: _____ Middle Initial: _____

Birth date: _____/_____/_____ Social Security Number: _____-_____-_____ Sex: ___M / F___

Marital Status: _____ Occupation/Employer: _____

Relation to Patient: _____ Email Address: _____

Name & Home Mailing Address of Responsible Party: Home Phone: _____

_____ Cell Phone: _____

_____ Work Phone: _____

_____ Emergency Contact Name: _____

Whom may we thank for referring you/ How did you Emergency Phone: _____

hear about our office? _____ Relationship: _____

CHECK ANY OF THE FOLLOWING YOU HAVE HAD, OR PRESENTLY HAVE:

☐	Heart Disease or Attack	☐	Ulcers	☐	Swelling in Joints
☐	High/Low Blood Pressure	☐	Cancer/Chemotherapy	☐	Pain in Jaw Joints
☐	Angina	☐	Kidney Trouble	☐	Tuberculosis (TB)
☐	Heart Murmur	☐	Liver Disease	☐	Glaucoma
☐	Rheumatic Fever	☐	Stroke	☐	Cortisone Medicine
☐	Congenital Heart Lesions	☐	Anemia	☐	Sinus Trouble
☐	Mitral Valve Prolapse	☐	Hemophilia	☐	Allergies or Hives
☐	Artificial Heart Valve	☐	Arthritis	☐	Diabetes
☐	Heart Pacemaker	☐	Epilepsy or Seizures	☐	Thyroid Disease
☐	Any Type of Surgery	☐	Prosthetics (Hip, Knee, Ear)	☐	Radiation Treatment
☐	Pregnant	☐		☐	

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

☐ Aspirin ☐ Local Anesthetic ☐ Erythromycin ☐ Nitrous Oxide ☐ Codeine ☐ Penicillin

Are you aware of being allergic to any other medications or substances? (YES / NO) Please List: _____

Please list any medications you are taking:

Are you interested in any cosmetic procedures: ☐ Yes ☐ No

If yes, please describe_____

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and 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 the insurance carrier and the Doctor and that I am fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balances and a minimum fee of $30 per half-hour appointment.

Patient Signature (Parent/Guardian of Child) _____ Date: ____/_____/_____

Dentist Signature _____