Douglas L. Evans, D.M.D., P.A.

"Complete Family Dental Care, Complete Comfort!"

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Welcome to Apalachee Bay Family Dental

Thank you for choosing our office. We strive to provide you with the most gentle, quality care possible. If you have any questions, or we can help you in any way, please feel free to ask.

Patient Information (Confidential):

Name_____ (If child, parent/guardian name)_____

Birthdate_____ Sex _____ Age_____ Soc. Sec. # _____

Home Address_____ City_____ State_____ Zip _____

Home Phone_____ Work Phone_____ Cell Phone_____

E-mail _____

Employer_____ Occupation _____

Employer Address_____ City_____ State_____ Zip ____

Spouse's Name (or other parent/guardian)

Spouse's Employer_____ Occupation _____

Spouse's Employer Address_____ City_____ State_____ Zip _____

If patient is a student: name of School/College _____

City & State_____ Full time/part time? _____

Who may we thank for referring you to our office? Referring Patient's Name _____

☐ Google ☐ Our Website ☐ OTHER _____

In Case of Emergency:

Someone we may contact, not living with you _____

Phone #'s: Home_____ Work_____ Cell _____

Authorization:

I authorize my insurance company to make payments directly to the dental office for benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions.

Signature:_____ Date: _____
Patient or Responsible Party

NO CHECKS ACCEPTED

Dental History

Patient Name_____ Age_____ Date_____

Reason for seeking care today: ____Exam ____Cleaning ____Specific Problem_____
(Please describe)

Please check all that apply:

- ☐ Toothache
- ☐ Broken filling or tooth
- Sensitivity to:
  - ☐ Cold
  - ☐ Hot
  - ☐ Sweets
  - ☐ Chewing
- ☐ Food Catches
- ☐ Loose Teeth
- ☐ Floss Breaks easily or hurts
- ☐ Bite or Teeth have Shifted
- ☐ Often Bite Cheeks
- ☐ Frequent Dry Mouth
- ☐ Concerned about Breath
- ☐ Unhappy with Previous Dental Work
- ☐ Gums Bleed
- ☐ Gums Tender
- ☐ Growths, Sores
- ☐ Cold Sores, Fever Blisters
- ☐ Cracked, Chapped Lips
- ☐ Bad Taste in Mouth
- ☐ Sinus Problems
- ☐ Mouth breathe-Difficulty Breathing through Nose
- ☐ Dry or Strained Eyes
- ☐ Shoulder, Neck or Headaches
- ☐ Clench or Grind Teeth
- ☐ Jaw Joint Pain
- ☐ Clicking or Popping of Joint
- ☐ Unable to Open Mouth Wide
- ☐ Jaw Gets Tired Easily
- ☐ Hold Things Between Teeth (Pipe, pencil, nails, pins)
- ☐ Bite Fingernails
- ☐ Unusual Habits with Teeth
- ☐ Wore Braces
- ☐ Previous Gum Treatment
- ☐ Previous Bite Treatment

Would you like whiter teeth?_____ Is there anything that bothers you (even just a little) about the appearance of your teeth or smile?

_____

Please rate 1-10 how anxious you are about dental treatment (1= totally relaxed)? _____

Have you ever had a bad experience at the dentist (Treatment? Staff? Billing?)_____

Name of Previous Dentist_____ Last visit with him/her _____

Why did you leave your previous dentist? _____

Medical History

Physicians Name_____

City_____ Phone_____

Have you been hospitalized for any reason? Please describe:

_____

_____

Are you taking any medications or drugs (including nutritional supplements?)

Please list: *(continue on back of form if needed)* _____

_____

_____

Are you allergic to penicillin, aspirin, local anesthetics, latex, sulfa, codeine, other? _____

_____

Do you smoke? How much/day? _____

Pregnant? Due Date_____ Are you nursing?_____

Are you seeing a physician now or planning to see one for any reason?

Please explain: _____

_____

_____

Please check all that apply:

- ☐ Previous injury to head or neck
- ☐ Heart Problem
- ☐ Heart Attack
- ☐ Angina, Chest Pain
- ☐ Heart Murmur
- ☐ Scarlet, Rheumatic Fever
- ☐ Mitral Valve Prolapse
- ☐ Irregular Heartbeat
- ☐ High or Low Blood Pressure
- ☐ Pacemaker
- ☐ Artificial Joint
- ☐ Diabetes
- ☐ HIV or AIDS
- ☐ Kidney Problem
- ☐ Liver Problem, Jaundice
- ☐ Cirrhosis, Hepatitis
- ☐ Cancer
- ☐ Radiation, Chemotherapy
- ☐ Respiratory Problem
- ☐ Bloody, Persistent Cough
- ☐ Asthma, Emphysema
- ☐ Anemia
- ☐ Sickle Cell
- ☐ Digestive Problem, Ulcer
- ☐ Thyroid Disease
- ☐ Glaucoma
- ☐ Bleed or Bruise Easily
- ☐ Stroke
- ☐ Epilepsy or Seizures
- ☐ Parkinson's
- ☐ Alzheimer's
- ☐ Back Problems
- ☐ Hives, Rash, Herpes
- ☐ Dry Eyes
- ☐ Shortness of Breath
- ☐ Snoring, Sleep Apnea
- ☐ Easily Winded
- ☐ No Energy
- ☐ Fainting or Dizzy
- ☐ Unexplained Weight Loss
- ☐ Chewing Tobacco
- ☐ Drug or Alcohol Addiction
- ☐ 2 or more Social Drinks/Day
- ☐ Anxiety or Nervous Disorder
- ☐ Insomnia
- ☐ Contact Lenses

Any other illness not checked above _____

Please indicate if you would prefer to speak privately with the dentist about a medical issue: ☐ YES ☐ NO

Please rate the following indicators of your daily stress level: 1-10 (1=low, 10=high)
___Overworked, too busy, pressured ___Feel Frustrated ___Get upset, or "snap" easily ___Depression, anxiety

I will inform this office of any changes in my health status. I understand that dental treatment and local anesthesia entail risks such as bleeding, infection, nerve damage, or fracture of teeth or bone. I certify that the above information is complete and accurate to the best of my knowledge.

Patient Signature (parent or guardian)_____ Date: _____

Dentist's Signature:_____ Date: _____