EVOLVE
DENTISTRY & AESTHETICS

Welcome!
NEW PATIENT FORM

Date : _____

PATIENT INFORMATION

First Name: _____ Last Name: _____

Birth Date: _____ Gender: ◯ Male ◯ Female

Preferred Name: _____ Preferred Pronouns: _____

Address: _____

City: _____ State: _____ ZIP _____

Email: _____ Cell Phone: _____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Other

Emergency Contact: _____ Phone: _____

Relationship to patient: _____

Patient Employer/School: _____ Occupation: _____

How did you hear about us?

◯ I live/work in area ◯ I was referred by _____

◯ Social media ◯ Google

◯ Other _____

INSURANCE INFORMATION

◯ No Dental Insurance ◯ Primary Insurance

Who is responsible for this account? _____

Relationship to Insurance holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other _____

Name of Insurance Company: _____ State: _____

Policy Holder Name: _____ Birth Date: _____

Policy Holder SS#: _____

Member ID: _____ Group #: _____

Name of Employer: _____

Is the patient covered by additional insurance? ◯ Yes ◯ No

Name of Insurance Company: _____ Group #: _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ *and assign directly*
(Name of Insurance company)
to Dr. Victoria McGowen all insurance benefits, if any, otherwise payable to me for any services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____
Patient Signature Date

DENTAL HISTORY

Previous Dentist: _____ Office Name: _____

City/State: _____ Date of last dental visit: _____

Date of last dental visit: _____

CHECK "YES" OR "NO" IF YOU HAVE HAD ANY OF THE FOLLOWING:

	Yes:	No:		Yes:	No:
Bad breath	◯	◯	Loose teeth or broken fillings	◯	◯
Bleeding or sore gums	◯	◯	Sensitvity to hot or cold	◯	◯
Ulcers on lip or tongue	◯	◯	Sensitvity to sweets	◯	◯
Burning sensation on tongue	◯	◯	Sensitvity when biting	◯	◯
History of smoking or vaping	◯	◯	Grinding or clenching	◯	◯
Clicking or popping of jaw	◯	◯	Jaw pain or tenderness	◯	◯

Any bad reactions to dental anesthesia in the past? ◯ Yes ◯ No

How anxious are you for dental treatment? ◯ None ◯ Slightly ◯ Very ◯ Extremely

MEDICAL HISTORY

Physician's Name: _____ Date of last visit: _____

Have you ever taken a bishosponate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ◯ Yes ◯ No

CHECK "YES" OR "NO" IF YOU HAVE HAD ANY OF THE FOLLOWING:

	Yes:	No:		Yes:	No:		Yes:	No:
High blood pressure	◯	◯	Diabetes	◯	◯	Arthritis, Rheumatism	◯	◯
Anemia	◯	◯	Thyroid Problems	◯	◯	Artificial joints	◯	◯
Heart Murmur	◯	◯	Acid Reflux	◯	◯	Back, Neck problems	◯	◯
Heart Problems	◯	◯	Kidney Disease	◯	◯	Cortisone treatments	◯	◯
Bleeding Disorders	◯	◯	Cirrhosis of liver	◯	◯	Epilepsy	◯	◯
Pacemaker	◯	◯	Asthma	◯	◯	Fainting or dizziness	◯	◯
Artificial Heart Valves	◯	◯	Emphysema	◯	◯	POTS	◯	◯
Congestive Heart Failure	◯	◯	Tuberculosis	◯	◯	History of cancer:	◯	◯
			Herpes	◯	◯	If yes, what type:_____		
AIDS/HIV	◯	◯	Hepatitis	◯	◯	Radiation treatment	◯	◯
History of heart attack	◯	◯				Pregnant	◯	◯
If yes, when was the last occurrence:_____						Currently nursing	◯	◯
History of stroke	◯	◯						
If yes, when was the last occurrence:_____								

MEDICATIONS/ALLERGIES

List any medications you are currently taking: _____

_____

_____

CHECK IF YOU ARE ALLERGIC TO ANY OF THE FOLLOWING:

◯ Local anesthetic ◯ Penicillin ◯ Sulfa drugs ◯ Aspirin ◯ Other _____