WILLIAM R. EVANS, D.D.S., A.P.C.

16635 Centerfield Drive
Eagle River, Alaska 99577
Phone (907) 694-5150

PATIENT _____ (Last Name / First Name / M.I.) Phone: Work _____ Home _____

Birthdate___/___/___ Social Security No. _____ ❑ Male ❑ Female ❑ Single ❑ Married Best time to call_____

Employer _____ Spouse's Name _____ Spouse's Employer _____

PERSON RESPONSIBLE FOR ACCOUNT ❑ Patient _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

REFERRED TO THIS OFFICE BY: _____

DENTAL INSURANCE:

Carrier _____

Carrier's Address _____

Subscriber's Name _____ **Birthday** _____

SS No. _____ **Group No.** _____

Home No. _____ **Work No.** _____

IF YOU HAVE ADDITIONAL INSURANCE COVERAGE:

Carrier _____

Carrier's Address _____

Subscriber's Name _____ **Birthday** _____

SS No. _____ **Group No.** _____

Home No. _____ **Work No.** _____

There are many medical situations which can affect or be affected by the procedures or drugs used for dentistry. Therefore, please fill out the following carefully. Thank you.

DATE OF LAST MEDICAL EXAM _____ Physician's Name _____ Phone _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING – INDICATE WITH (X)

_ Allergies to drugs
_ Allergies to anesthetics (Novacaine)
_ Any heart ailments/heart murmur
_ High blood pressure
_ Neurological problems
_ Radiation treatments
_ Excessive bleeding from cut or extractions
_ Anemia or blood problems
_ Arthritis
_ Fainting or dizzy spells
_ Asthma
_ Hay fever or allergies in general
_ Diabetes
_ Kidney problems
_ Liver problems
_ Malignancies
_ Psychiatric care/emotional problems
_ Rheumatic fever
_ Sinus problems
_ Epilepsy
_ Stroke
_ Thyroid
_ Eye disorders
_ Tonsillitis
_ Tuberculosis
_ Ulcer or colitis
_ Pregnancy,
If so, what month _____
_ Venereal disease
_ Herpes
_ Hepatitis
_ HIV Positive
_ Phen-Fen

PLEASE: describe any current medical treatment, including drugs, impending operations, pregnancies or other information Dr. Evans should be aware of:

_____

_____

_____

Are you taking drugs for: High blood pressure _____ Cortisone or steroids _____ Blood thinners _____ Sedatives or tranquilizers _____

Other _____

_____

DATE OF LAST DENTAL EXAM _____ ANY PREVIOUS MAJOR DENTAL TREATMENT [ ] Yes [ ] No When? _____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING – INDICATE WITH (X)

_ Teeth sensitive to cold, heat, sweets or pressure
_ Bleeding gums. How long? _____
_ Food impaction
_ Clenching or grinding
_ Burning of tongue
_ Swelling or lumps in mouth
_ Frequent blisters on lips or mouth
_ Pain around ear
_ Unusual sounds in ear while eating
_ Bad breath
_ Unpleasant taste
_ Unfavorable dental experience
_ Complications from extractions
_ Periodontal (gum) treatment
_ Orthodontic treatment (braces)
_ Mouth breathing
_ Oral habits, i.e., fingernail biting, cheek biting, etc.
_ Cigarettes, pipe or cigar smoking
_ Texture of toothbrush _____
_ Frequency of brushing _____
_ Dental floss
_ Inter dental stimulators
_ Water jet device
_ Disclosing tablets or solution
_ Fluoride supplements
_ Headaches

I hereby certify that the above information is true and correct.

Signed: _____ Date: _____

Patient – Parent or Guardian (if under 18)