Chart #:
FOR OFFICE USE ONLY

Patient Information

Patient Name: ______________________________ Date: __________
Last, First MI (Preferred Name)

Gender: __________ Family Status: __________

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): __________ (Work): __________ Ext: ______ Best time to call: __________

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: ____
Street Apartment #
City State Zip Code

Health Information

Date of Last Dental Visit: __________ Reason for this visit: ______________________

Have your ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies __________ __________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy**
  Due date:__________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:
- ☐ __________________
- ☐ __________________

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of Physician: ______________________________ Phone: __________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____
- Do you currently take any medications? If, yes please list:

____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

X____ Date:____________________

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ______________________________

Insurance Information

Primary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ______________ ID #: ______________ Group #: ______________

Street City State Zip Code

Insured's Employer Name: ______________________________

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ______________________________

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Secondary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ______________ ID #: ______________ Group #: ______________

Insured's Employer Name: ______________________________

Address: ______________________________

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ______________________________

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Insurance release

I authorize Evergreen Dental Center to release my information and or xrays/photos to my insurance company. I understand this is for the purposes of billing my insurance company. I hereby authorize Evergreen Dental Center PLLC to provide any insurance company (s), claim administrator(s) and consulting healthcare professional(s), information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluation and administering claims for benefits. I further authorize payment directly to Evergreen Dental Center PLLC.

Signature of patient, parent or guardian______________________________ Date______________

Notice of Privacy Practices

I have received a copy of Evergreen Dental Center PLLC's Notice of Privacy Practices.

Signature of patient, parent or guardian______________________________ Date______________

Responsible Party for payment Information
(if patient is under 18)

The following is for: ☐ parent or guardian ☐ other, ______________

Name: ______________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): ______________ (Work): ______________ Ext: ______ Best time to call: ______________

Address: ______________________________

Street Apartment #

____

City State Zip Code

Signature of patient, parent or guardian______________________________ Date______________

Release of Dental Information Consent

Can Evergreen Dental leave a message on my answering machine or voicemail?	Yes	No
Call we leave a message with a person that answers?	Yes	No
Can Evergreen Dental call your home number?	Yes	No
Can Evergreen Dental call your work number?	Yes	No
Can Evergreen Dental call your cell phone number?	Yes	No

Please list any persons we are authorized to speak with regarding your Account or clinical treatment:

1.____relationship__________________

2.____relationship__________________

Please list at least one person we may contact in the event of an emergency:

1.____relationship__________________

Consent for Services

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by Dr Charlotte Cortis and Dr Jason Hartman, Evergreen Dental Center PLLC, I agree to pay therefore the reasonable value of said services to said Doctor(s), or his/here assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I agree to pay all fees that my insurance does not pay. I understand and agree that payment is due at the time services are rendered and that health, dental and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that this office will prepare any necessary dental reports and dental forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me will be charged directly to me and that I am personally responsible for payment, regardless of insurance. I agree to pay all fees that my insurance does not pay. In the event my account balance is referred to any agency or attorneys for collection purposes, I agree to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court cost. In the event that the patient is a minor, I am the parent and /or guardian of said patient and agree that I am responsible for all services rendered the patient herein. I understand that if I suspended or terminate any care and treatment to me or to any person referred to in the previous sentence, any fees fro professional services rendered, including interrupted service fees if applicable, will be immediately due and payable. I understand if my account is not paid within 90 days I may be subject to an annual interest rate of 1.75%. Evergreen Dental Center PLLC offers the following payment options: Cash, personal check, Visa, Mastercard, CareCredit.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

I understand that my proposed treatment plan and fees are subject to modifications, depending upon unforeseen or undiagnosed conditions that may be recognized during the course of treatment. I understand that it may be necessary to change or add procedures. I authorize Dr Charlotte Cortis, Dr Jason Hartman, and the clinical staff at Evergreen Dental Center PLLC to use their professional judgment to provide appropriate treatment.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

______________________________ Date: __________ Relationship to Patient: ______________
Signature of patient, parent or guardian

______________________________ Date: __________ Relationship to Patient: ______________
Signature of guarantor of payment/responsible party