PATIENT INFORMATION
(Please Print)

EVON T. HEASER D.D.S. PC
160 NUCLEUS AVENUE
PO BOX 2065
COLUMBIA FALLS, MT 59912

ABOUT YOU

Today's Date: _____/_____/_____

Patient Name: _____

What You Prefer To Be Called: _____ ❒ Male ❒ Female

Birthdate: _____/_____/_____ Age: _____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Address: (if different) _____

_____
CITY STATE ZIP

Home Phone # : _____

Work Phone#: _____ Ext: _____

Cell Phone #: _____ Email: _____

Circle Contact Preference: Home Work Cell Text Email

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: ☐Minor ☐ Single ☐Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse or Parent's Name (s): _____ SS # _____

I give my consent to have my films & photos used for educational purpose.

X _____

INSURANCE INFO

Primary Dental Insurance

Co. Name: _____

Address: _____

_____

Subscriber Name _____

Relation to Patient _____

SS #: _____ DOB: ___/___/____

Address _____

Home Ph: _____ Work Ph: _____

Insurance Co.: _____

Group# _____

ID# _____

Employer: _____

PRIVACY PRACTICE NOTICE HIPPA

I acknowledge that I have received a Notice of Privacy Practices from this office.

_____
Signature Date

If a personal representative signs this on behalf of the individual, complete the following:

Personal Representative's Name:

_____

Relationship to individual:

_____

ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____

SS#: _____

Drivers License #: or I.D. # _____

Work Phone #: _____ Ext _____

Payment method: ☐Cash/Check ☐Master Card ☐Visa ☐Discover ☐Care Credit

_____ _____/_____
Enter Card # above (if accepted) CVD# ____ ____ ____ ____

I Authorize Evon T. Heaser DDS to charge my card on any balance exceeding 90 days. I may cancel this agreement at anytime through written notice.

X _____ **Date** _____

IN EVENT OF EMERGENCY

Who should we contact: _____

Relation: _____

Home Phone#: _____

Work Phone #: _____ Ext. _____

Who is your Medical Doctor? _____

M.D.'s Phone #: _____

PAYMENT AGREEMENT

It is understood that **payment in full** is to be made at time of each service provided by Evon T. Heaser, D.D.S., unless credit arrangements have been made in advance. **I have received a copy of the financial policy**. Our staff will gladly aid you with any difficulties you may have in filing your insurance or problems you may incur after you file.

X _____
Signature of Person Responsible for Account **Date**

PLEASE COMPLETE MEDICAL HISTORY ON REVERSE SIDE

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you undergoing Medical treatment at this time? O **Yes** O **No** If yes, please explain: _____

Have you ever been hospitalized or had a major operation? O **Yes** O **No** If yes, please explain: _____

Have you ever had a serious head or neck injury? O **Yes** O **No** If yes, please explain: _____

Are you taking any medications, pills, or drugs? O **Yes** O **No** If yes, please list: _____

_____.

Do you take or have you taken, Phen-Fen or Redux? O **Yes** O **No** If yes, please explain: _____

Are you on a special diet? O **Yes** O **No** If yes, please explain: _____

Do you use tobacco? O **Yes** O **No** If yes, please explain: _____

Do you use controlled substances? O **Yes** O **No** If yes, please explain: _____

Are you being treated for Osteoporosis? O **Yes** O **No** If yes, please explain: _____

Are you taking Fosamax, Boniva or Actonel? O **Yes** O **No** If yes, please explain: _____

Women: Are you
Pregnant/Trying to get pregnant? O **Yes** O **No** Taking Oral Contraceptives? O **Yes** O **No** Nursing? O **Yes** O **No**

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

Aids/HIV Positive	O **Yes** O **No**	Cortisone Meds	O **Yes** O **No**	Hemophilia	O **Yes** O **No**	Renal Dialysis	O **Yes** O **No**
Abnormal Bleeding	O **Yes** O **No**	Diabetes	O **Yes** O **No**	Hepatitis A	O **Yes** O **No**	Rheumatic Fever	O **Yes** O **No**
Alzheimer's Disease	O **Yes** O **No**	Drug Addiction	O **Yes** O **No**	Hepatitis B or C	O **Yes** O **No**	Rheumatism	O **Yes** O **No**
Anaphylaxis	O **Yes** O **No**	Easily Winded	O **Yes** O **No**	Herpes	O **Yes** O **No**	Scarlet Fever	O **Yes** O **No**
Anemia	O **Yes** O **No**	Emphysema	O **Yes** O **No**	High Blood Pressure	O **Yes** O **No**	Seizures	O **Yes** O **No**
Angina	O **Yes** O **No**	Epilepsy or Seizures	O **Yes** O **No**	Hives or Rash	O **Yes** O **No**	Shingles	O **Yes** O **No**
Arthritis/Gout	O **Yes** O **No**	Excessive Bleeding	O **Yes** O **No**	Hypoglycemia	O **Yes** O **No**	Shortness of Breath	O **Yes** O **No**
Artificial Joint What Type: Date Placed:	O **Yes** O **No** _____ _____	Excessive Thirst	O **Yes** O **No**	Irregular Heartbeat	O **Yes** O **No**	Sickle Cell Disease	O **Yes** O **No**
Artificial Heart Valve	O **Yes** O **No**	Fainting Spells/ Dizziness	O **Yes** O **No**	Kidney Problems	O **Yes** O **No**	Sinus Trouble	O **Yes** O **No**
Asthma	O **Yes** O **No**	Frequent Cough	O **Yes** O **No**	Leukemia	O **Yes** O **No**	Spina Bifida	O **Yes** O **No**
Blood Disease	O **Yes** O **No**	Frequent Diarrhea	O **Yes** O **No**	Liver Disease	O **Yes** O **No**	Stomach/Intestinal Disease	O **Yes** O **No**
Blood Transfusion	O **Yes** O **No**	Frequent Headaches	O **Yes** O **No**	Low Blood Pressure	O **Yes** O **No**	Stroke	O **Yes** O **No**
Breathing Problem	O **Yes** O **No**	Genital Herpes	O **Yes** O **No**	Lung Disease	O **Yes** O **No**	Swelling of Limbs	O **Yes** O **No**
Bruise Easily	O **Yes** O **No**	Glaucoma	O **Yes** O **No**	Mitral Valve Prolapse	O **Yes** O **No**	Thyroid Disease	O **Yes** O **No**
Cancer	O **Yes** O **No**	Hay Fever	O **Yes** O **No**	Pain in Jaw Joints	O **Yes** O **No**	Tonsillitis	O **Yes** O **No**
Chemotherapy	O **Yes** O **No**	Heart Attack/Failure	O **Yes** O **No**	Parathyroid Disease	O **Yes** O **No**	Tuberculosis	O **Yes** O **No**
Chest Pains	O **Yes** O **No**	Heart Murmur	O **Yes** O **No**	Psychiatric Care	O **Yes** O **No**	Tumors or Growths	O **Yes** O **No**
Cold Sores/Fever Blisters	O **Yes** O **No**	Heart Pace Maker	O **Yes** O **No**	Radiation Treatments	O **Yes** O **No**	Ulcers	O **Yes** O **No**
Congenital Heart Disorder	O **Yes** O **No**	Heart Disease/Trouble	O **Yes** O **No**	Recent Weight Loss	O **Yes** O **No**	Venereal Disease	O **Yes** O **No**
Convulsions	O **Yes** O **No**					Yellow Jaundice	O **Yes** O **No**

Have you ever had any serious illness not listed above? O **Yes** O **No** If yes, please explain: _____
Comments: _____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ **DATE** _____