Lawson Evans, DDS

1805 Novato Blvd., Ste. 4, Novato, CA 94947 (415) 898-0696

Date _____

PATIENT INFORMATION

Mr./Mrs./Miss/Ms. _____ Date of Birth _____
Last Name First Name Middle Name

Mailing Address _____ Home Phone (____) _____
Street City State Zip

Email Address _____ Work Phone (____) _____

Social Security Number ____ - ____ - ____ Sex ❑ M ❑ F Cell Phone (____) _____

Occupation _____ Employer _____
Company Street City State Zip

Are you a full time student? _____ Name of school _____ Do you qualify on parent's insurance? _____

If Kaiser Med. Ins., Med. # _____ Previous Dentist _____ Date last seen _____

1. Are you having pain or discomfort at this time? . . . . . YES NO
2. Have you been under the care of a physician or hospitalized during the past two years? . . . . . YES NO
   Physician's Name, Address & Phone No. _____
3. Person to contact in case of emergency _____ Phone # _____
4. Are you now taking or have taken any medication, drugs or pills? . . . . . YES NO
   If yes, please list: _____
5. Have you had unfavorable or allergic reactions to any of the following? Circle YES or NO to each item.

Penicillins . . . . . YES NO	Codeine . . . . . YES NO	Aspirin . . . . . YES NO
Antibiotics . . . . . YES NO	Pain Medications . . . . . YES NO	Epinephrine . . . . . YES NO
Latex . . . . . YES NO	Other, please list: _____	

6. Indicate which of the following you have had or have at present. Circle YES or NO to each item.

Prosthetic Cardiac Valve . . . . . YES NO	Chemotherapy . . . . . YES NO	Arthritis . . . . . YES NO
Previous Endocarditis . . . . . YES NO	High Blood Pressure . . . . . YES NO	Cancer . . . . . YES NO
Unrepaired Cyanotic Congenital Heart Disease . . . . . YES NO	Drug/Alcohol Addiction . . . . . YES NO	Taken Phen-Fen . . . . . YES NO
	Stroke . . . . . YES NO	Taken Bisphosphonate . . . . . YES NO
Cardiac Prosthetic Device . . . . . YES NO	Parkinson's Disease . . . . . YES NO	Heart Pacemaker . . . . . YES NO
Cardiac Transplant . . . . . YES NO	Asthma . . . . . YES NO	Bruise Easily . . . . . YES NO
Artificial Joints (hip, knee, etc.) . . . YES NO	Thyroid Problems . . . . . YES NO	Epilepsy or Seizures . . . . . YES NO
Heart Attack . . . . . YES NO	Glaucoma . . . . . YES NO	Fainting or Dizzy Spells . . . . . YES NO
Heart Disease . . . . . YES NO	Cosmetic Surgery . . . . . YES NO	Psychiatric Treatment . . . . . YES NO
Diabetes . . . . . YES NO	Emphysema . . . . . YES NO	History of taking: Phen-fen . . . . YES NO
Tuberculosis . . . . . YES NO	Sinus Trouble . . . . . YES NO	History of taking: Bisphosphonate . YES NO
Hepatitis B . . . . . YES NO	Radiation Therapy . . . . . YES NO	
A.I.D.S. or H.I.V. Positive . . . . . YES NO	Kidney Trouble . . . . . YES NO	

7. Have you noticed any of the following? Circle YES or NO to each item.

Teeth tender to chew on . . . . . YES NO	Recurring sore in or around the mouth . . . . . YES NO
Discomfort in face, head, neck . . . . . YES NO	Jaw clicking or popping . . . . . YES NO
Swelling, lumps in mouth . . . . . YES NO	Sensitivity to hot or cold . . . . . YES NO
Bleeding or sore gums . . . . . YES NO	Do you floss regularly . . . . . YES NO
Sensitivity to sweets . . . . . YES NO	Do you smoke . . . . . YES NO

8. Do you have or have you had any disease, condition, or problem not listed? . . . . . YES NO
   If yes, please list: _____

FOR WOMEN ONLY:

Are you pregnant? ❑ YES, what month? ____ ❑ NO Are you nursing? ❑ YES ❑ NO Are you taking birth control pills? ❑ YES ❑ NO

CONSENT:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.

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

Patient Signature: _____ Date: _____ **OR** Guardian Signature: _____ Date: _____