EVP EAST VALLEY PERIODONTICS

PATIENT DETAILS DATE: _____

First Name of Patient: _____

Preferred Name: _____

Last Name of Patient: _____

Date of Birth: _____

Gender: _____

Marital Status: _____

Email Address (responsible party): _____

Cell Phone Number: _____

Other Phone Number: _____

Physical Address: _____

City, State, Zip Code: _____

Mailing Address (if different): _____

Patient (or parent of minor) SSN: _____

Patient (or parent) DL #: _____

Employer, School or Retired: _____

PRIMARY INSURANCE

Dental Insurance Company Name: _____

Employer or Retired: _____

Subscriber Name: _____

Subscriber Birth Date: _____

Group #: _____

Subscriber SSN or Member ID#: _____

Subscriber Address (if different): _____

City, State, Zip Code: _____

SECONDARY INSURANCE

Dental Insurance Company Name: _____

Employer or Retired: _____

Subscriber Name: _____

Subscriber Birth Date: _____

Group #: _____

Subscriber SSN or Member ID#: _____

Subscriber Address (if different): _____

City, State, Zip Code: _____

The Doctors at EVP are educators within the dental community. We take photos and/or videos as visual aids to help with our educational presentations, website or social media. We always protect our patient's privacy and identity when using media.
Please mark your preference for the use of your photos/videos: ☐ Yes ☐ No

Appointment confirmations may be completed by text, phone call, voicemail and/or email ☐ I understand

Statements for account balances are sent by text, email and/or mail ☐ I understand

Signature: _____

HEALTH HISTORY Patient Name: _____ Date: _____

Who may we thank for referring you?

_____

Reason for referral/dental complaints?

_____

Name of your dentist:

_____

How long have you been a patient there?

_____

Your Physician:

_____

Phone:

_____

Pain Management Specialist:

_____

Your Cardiologist:

_____

Phone:

_____

Pharmacy Name & Location:

_____

Pharmacy Phone:

_____

Emergency Contact Name:

_____

Relationship:

_____

Phone:

_____

Date of Last Physical Exam:

_____

Are you presently under a Physician's care?

_____

Hospitalized in the last 3 years?

_____

Height: _____

Weight: _____

DO ANY OF THE FOLLOWING APPLY TO YOU?

▢ Take a GLP-1	▢ Heart murmur	▢ Heart trouble	▢ High blood pressure
▢ Low blood pressure	▢ Chest pains	▢ History of stents, heart attack, stroke	▢ Latex allergy
▢ Penicillin/Amoxicillin allergy	▢ Sulfa allergy	▢ Any other drug allergies	▢ Asthma
▢ Dementia or Alzheimers	▢ Sinus issues	▢ Seasonal allergies	▢ Epilepsy or seizures
▢ Diabetes (Type 1)	▢ Diabetes (Type 2)	▢ Arthritis or rheumatism	▢ Joint replacement
▢ Hepatitis, jaundice or liver disease	▢ Stomach or duodenal ulcers	▢ Kidney disease or infections	▢ AIDS or HIV
▢ STD	▢ Nervous tendencies	▢ Cancer	▢ Chemo and/or radiation
▢ Prolonged bleeding following tooth extraction	▢ Anemia	▢ Clotting issues	▢ Take blood thinner
▢ Cannot take NSAIDs (Ibuprofen)	▢ Take (or have taken) meds for osteopenia/osteoporosis	▢ COPD	▢ Sleep Apnea
▢ Vape	▢ Use medical marijuana	▢ Use other recreational drugs	▢ Smoke cigars/cigarettes
▢ None			

WOMEN ONLY:

▢ Pregnant or trying	▢ Taking birth control	▢ Post-menopausal	▢ None

FOLLOW UP QUESTIONS: Patient Name: _____ Date:_____

If other drug allergies, to what:

_____

If you have diabetes, what and when was your latest A1C?

_____

If you've had a joint replaced, which joint and when?

_____

If you have/had cancer, what type and when? Is it in remission?

_____

Does your medical doctor require you to take an antibiotic prior to dental work being done?

_____

If you have osteopenia/osteoporosis, what meds do you take?

_____

If you take a blood thinner, what is the name of the medication?

_____

If you smoke, vape or use marijuana or other drugs, how much/often:

_____

Do you have any other serious illnesses we should know about?

_____

Please list all medications you take (or bring a list in to your appointment):

_____
_____

DENTAL HISTORY

DO ANY OF THESE APPLY TO YOU?

- ▢ Periodontal osseous surgery
- ▢ Periodontal scaling & root planing
- ▢ Bleeding gums
- ▢ Sore, sensitive teeth
- ▢ Dental implants
- ▢ Grind teeth (day or night)
- ▢ Clench jaw (day or night)
- ▢ Pain in jaw joint
- ▢ Clicking in jaw
- ▢ Pain elsewhere in face or jaw
- ▢ Orthodontics

If history of perio treatment, when was this done?

_____

Select the devices used in your oral care:

- ▢ Toothbrush (manual)
- ▢ Toothbrush (electric)
- ▢ Floss
- ▢ Water Irrigation
- ▢ Toothpicks or Go-betweens
- ▢ Other

Signature: _____