Patient Name:_____ Date: _____

Who may we thank for your referral?_____

Reason for referral_____

Present Dental Complaints:_____

Your Dentist:_____How long have you been a patient there?: _____

Your Physician:_____Phone:_____

Your Cardiologist: _____ Phone: _____

Pharmacy Name and Location: _____ Phone: _____

Emergency Contact Name: _____ Relationship: _____ Phone:_____

MEDICAL / HEALTH HISTORY

Date of Last Physical Exam:_____

Are you presently under a Physician's Care? Yes No

Have you been hospitalized in the last 3 years? Yes No

For what condition?_____

Do any of the following apply to you?

Do you have any of the following heart conditions:

Rheumatic Fever: Yes No

Heart Murmur: Yes No

Heart Trouble: Yes No

High Blood Pressure: Yes No

Chest Pains: Yes No

History of stents, heart attack, stroke: Yes No

Other Heart Issues: _____

Do you have any Drug Allergies: Yes No

If Yes, to what: _____

Asthma, hay fever, sinus issues, or allergies: Yes No

Epilepsy or seizures: Yes No

Do you have Diabetes (Type 1 or 2): Yes No

Average blood suger reading: _____

Last A1C Score: _____

Arthritis or rheumatism: Yes No

Have you have a joint replaced: Yes No

If Yes, which joint(s): _____

When: _____

Hepatitis, jaudice or liver disease: Yes No

Stomach or duodenal ulcers: Yes No

Kidney disease or infections: Yes No

Have you ever tested postive for AIDS or HIV: Yes No

Have you tested positive for Veneral Disease: Yes No

Have you ever had medical x-ray treatments: Yes No

Prolonged bleeding following tooth extraction: Yes No

Anemia: Yes No

Clotting Problems: Yes No

Any other abnormal bleeding problems or disorders: Yes No

If Yes, what: _____

Glaucoma: Yes No

Do you wear contact lenses: Yes No

Do you take blood thinners: Yes No

If Yes, which one: _____

Does your medical doctor require you to take an antibiotic prior to dental work being done: Yes No

Do you take or have you ever taken any bisphosphonates used to treat osteoporosis (i.e. Boniva, Fosamax): Yes No

Are you a nervous person: Yes No

If Yes, do you take medications for this: Yes No

If Yes, which one: _____

Do you take any other drugs or medications: Yes No

If Yes, what: _____

_____

_____

_____

_____

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

If Yes, what: _____Yes No

Do you smoke, vape, chew tobacco or use medical marijuana?

If Yes, how much/often: _____ Yes No

Do you use other recreational drugs? Yes No

If Yes, what: _____

WOMEN: Are you pregnant or trying to get pregnant: Yes No

Do you take birth control pills: Yes No

Are you presently in or are you post-menopausal: Yes No

DENTAL HISTORY

Have you ever had periodontal treatment: Yes No

If Yes, when and what: _____

Do your gums bleed: Yes No

Do you have sore, sensitive teeth: Yes No

Have you ever had dental implants: Yes No

Do you grind your teeth day or night: Yes No

Do you clench your daw day or night: Yes No

Do you have pain in your jaw joint area: Yes No

Do you notice clicking in your jaw: Yes No

Do you have pain elsewhere in your face or jaw: Yes No

Have you had your teeth straightened (ortho): Yes No

If Yes, when: _____

Circle the devices used in your oral care:

Floss, Toothpicks, Water Irrigation, Electric Toothbrush, Other

Signature: _____

Date:_____

Name:_____ Birth Date:_____

Marital Status:_____ Email Address: _____
(if minor, enter email for responsible party)

Telephone:_____ Cell: _____

Physical Address:_____
City:_____State:_____Zip:_____

Mailing Address:_____
City:_____State:_____Zip:_____

SSN:_____ DL#/State:_____

Employer or School: _____ Retired? Y / N

Primary Dental Insurance Company: _____
Subscriber Name: _____ Employer or Retired: _____
Subscriber Birth Date: _____ Group Number:_____
Subscriber SSN or Member ID #:_____
Subscriber Address: _____
City: _____ State: _____ Zipcode: _____

Secondary Dental Insurance Company: _____
Subscriber Name: _____ Employer or Retired:_____
Subscriber Birth Date: _____ Group Number:_____
Subscriber SSN or Member ID #:_____
Subscriber Address: _____
City: _____ State: _____ Zipcode: _____

Informed Consent (Initial lines below):

____ Appointment confirmations may be completed by text, phone call, voicemail and/or email

____ Statements for account balances are sent by text, email and/or mail

Photo Consent (Circle answer below):

The Doctors at EVP are educators within the dental community around us. Often times we take photos and/or videos of our cases as visual aids to help with our educational presentations and we will occasionally use them on our website or social media. We are always careful to protect our patient's identity when using photos and videos. Please mark below your preference for the use of your photos and videos.

YES NO