EVENSKY
Periodontics & Dental Implants

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Board Certified in Periodontology and Dental Implant Surgery

Welcome to the Practice

PATIENT INFORMATION

Date_____

☐Mr. ☐Mrs. ☐Ms. ☐Dr. First Name _____ M.I._____ Last Name_____

Nickname_____ E-mail_____

Sex: ☐Male ☐Female DOB_____ Age_____ Soc. Sec. #_____

Street _____ City_____ State_____ Zip_____

Home # (_____)_____Cell # (_____)_____ Pharmacy # (_____)_____

Have you ever been a patient of Dr. Evensky? ☐Yes ☐No

Dentist _____ Referred By _____

Medical Doctor _____

Would you like us to send a copy of your records to your medical doctor? ☐ Yes ☐ No

Driver's Lic. # _____

Employer_____ Bus. Tel. (_____)_____

In case of emergency, please contact _____ Tel. (_____) _____

Relation_____

PRIMARY DENTAL INSURANCE COMPANY

Are you the policy holder? ☐ Yes ☐ No

If NO, relation to patient _____

Insurance Co. Name_____

Group # _____ **Group Name**_____

Address_____

_____

Tel. (_____)_____

Insured Party Information

Name _____ DOB_____

S.S.#_____ I.D.# _____

Address_____

City, State, Zip _____

Tel. (_____)_____

Employer _____

Bus. Address/Street _____

Bus. Tel. (_____)_____

WHO WILL BE *FINANCIALLY* RESPONSIBLE FOR YOUR ACCOUNT?

☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other _____

Name _____ S.S. #_____ DOB_____

Street _____ City_____ State_____ Zip_____

Home Tel. (_____) _____ Cell (_____) _____

Employer _____ Bus. Tel. (_____)_____

SPOUSE OR OTHER GUARDIAN INFORMATION *(if different from above)*

Name _____ S.S. #_____ DOB_____

Street _____ City_____ State_____ Zip_____

Home Tel. (_____) _____ Cell (_____) _____

Employer _____ Bus. Tel. (_____)_____

Signature _____

Name _____

DENTAL INFORMATION

Reason for today's visit: ☐ Exam ☐ Consultation ☐ Emergency

Are you in pain? ☐ Yes ☐ No, For How Long?_____

Please indicate any of the following problems by checking off the corresponding box:

☐ Discomfort, clicking, or popping in jaw
☐ Red, swollen, or bleeding gums
☐ A removable dental appliance
☐ Blisters / sores in or around the mouth
☐ Prolonged bleeding from an injury / extraction
☐ Recent infections or sore throat
☐ My teeth are sensitive to: ☐ Hot ☐ Cold ☐ Sweets ☐ Biting
☐ Lost / broken filling(s)
☐ Teeth grinding / clenching
☐ Ringing in ears
☐ Broken / chipped tooth
☐ Gum disease
☐ Toothache
☐ Stained teeth
☐ Locking jaw
☐ Bad breath
☐ Other:
☐ Burning tongue / lips
☐ Difficulty closing jaw
☐ Difficulty opening jaw
☐ Loose / shifting teeth
☐ Food caught between teeth
☐ Swelling / lumps in mouth

DENTAL HISTORY

Last professional dental exam_____ Last dental x-rays_____

Have you had previous periodontal therapy? ☐ Yes ☐ No

If so, please describe _____

Times a day you brush?_____ Times a week you floss?_____

What type of tooth bristles do you use? ☐ Soft ☐ Medium ☐ Hard

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

MEDICAL HISTORY

DO YOU REQUIRE AN *ANTIBIOTIC* PRE-MEDICATION PRIOR TO YOUR DENTAL VISIT? ☐ YES ☐ NO

Are you in good health? ☐ Yes ☐ No Height_____ Weight_____ Are you under the care of a physician? ☐ Yes ☐ No

Have you had any illness, operation, or been hospitalized in the past five years? ☐ Yes ☐ No

Please explain_____

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N	
☐	☐	Rheumatic fever	☐	☐	Are you immunosuppressed? (possibly from transplant surg.)	☐	☐	Gallbladder trouble
☐	☐	Mitral valve prolapse	☐	☐	Contagious diseases	☐	☐	Convulsions/Epilepsy
☐	☐	Heart murmur	☐	☐	Asthma	☐	☐	Stroke
☐	☐	High blood pressure	☐	☐	Hay fever/Sinus problems	☐	☐	GERD
☐	☐	Low blood pressure	☐	☐	Snoring/Sleep apnea	☐	☐	Thyroid trouble
☐	☐	Low blood sugar	☐	☐	Respiratory problems	☐	☐	Diabetes ☐ Type 1 or ☐ Type 2
☐	☐	Chest pain / Angina	☐	☐	Bronchitis/Chronic cough	☐	☐	Swollen ankles
☐	☐	Heart attack(s)	☐	☐	Tuberculosis	☐	☐	Kidney trouble
☐	☐	Irregular heart beat	☐	☐	Emphysema	☐	☐	Are you on dialysis
☐	☐	Cardiac pacemaker	☐	☐	Do you smoke	☐	☐	Stomach ulcers
☐	☐	Heart surgery	☐	☐	Do you use chewing tobacco	☐	☐	Arthritis/Joint disease/Osteoporosis
☐	☐	Hyper Cholesterol	☐	☐	Blood transfusion	☐	☐	Joint Replacement
☐	☐	Congestive Heart Failure	☐	☐	Blood disorder	☐	☐	Tumor or growth
☐	☐	Damaged heart valves	☐	☐	Bruise easily	☐	☐	Radiation/Chemotherapy/Cancer
☐	☐	Fainting spells	☐	☐	Bleeding tendency	☐	☐	Are you on a diet
☐	☐	Malignant hyperthermia	☐	☐	Jaundice/Liver disease	☐	☐	Contact lenses
☐	☐	Chronic fatigue/Night sweat	☐	☐	Anemia	☐	☐	Eye disease/Glaucoma
☐	☐	Infectious mononucleosis	☐	☐	Hepatitis ☐ A ☐ B or ☐ C	☐	☐	Mental health problems
☐	☐	Problems w/immune system? (possibly from med./surg.)	☐	☐	Sexually transmitted diseases	☐	☐	A history of alcohol abuse
☐	☐	Delay in healing	☐	☐	Abnormal bleeding	☐	☐	A history of drug abuse

Name _____

MEDICATION AND ALLERGIES

Are you now taking any of the following:

Y	N		Y	N		Y	N	
☐	☐	Anxiety Medication	☐	☐	Pain killers (including aspirin)	☐	☐	Insulin
☐	☐	Have you ever taken diet pills	☐	☐	Tranquilizers	☐	☐	Stimulants
☐	☐	Blood thinners (Coumadin, Aspirin, Advil)	☐	☐	Muscle relaxers	☐	☐	Antidepressants
☐	☐	Any bone density medication or Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)						

Please list other medication(s) and dosage you are taking (including natural, herbal, or homeopathic products):

Are you allergic to or had a reaction to:

Y	N		Y	N		Y	N	
☐	☐	Amoxicillin	☐	☐	Penicillin	☐	☐	Eggs / Yolk
☐	☐	Aspirin	☐	☐	Sulfa drugs	☐	☐	Iodine
☐	☐	Clindamycin	☐	☐	Valium or other tranquilizers	☐	☐	Shellfish
☐	☐	Codeine or other narcotics	☐	☐	Latex	☐	☐	Soy
☐	☐	Local anesthetic (numbing med)				☐	☐	Sulfites

Please list any other medication or antibiotic you are allergic to:

Please list any allergies other than drug allergies:

1-4 below for women only: *(women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. consult your physician / gynecologist for assistance regarding additional methods of birth control.)*

1) Is there a possibility of pregnancy? ☐ Yes ☐ No

2) Expected delivery date:_____

3) Are you nursing? ☐ Yes ☐ No

4) Are you taking birth control pills: ☐ Yes ☐ No

I certify that I have read and I understand the question above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient and/or responsible party: X_____

Reviewed by: X_____ **Date:** X_____

OFFICE USE ONLY - CLINICAL NOTES

BP	Pulse