Pinnacle
Dental Group

# PATIENT INFORMATION

**First Name:** _____ **MI:** _____ **Last:** _____ **Nick Name:** _____

**Home Phone:** _____ **Work Phone:** _____ **Cell Phone:** _____

**DOB:** _____ ☐ **Male** ☐ **Female** **SS#:** _____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Employer:** _____

**State ID/Driver's License #:** _____ **E-mail Address:** _____

**Name of Physician:** _____ **Physician Phone:** _____

**In case of Emergency Contact:** _____ **Relationship:** _____ **Phone:** _____

**How did you hear about our office?** _____

## Patient Health History

**Do you have a history of:**

| | Yes | No | | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|
| A.I.D.S/HIV Positive | ☐ | ☐ | Excessive Bleeding | ☐ | ☐ | Jaundice | ☐ | ☐ | Respiratory Problems/Disorders | ☐ | ☐ |
| Alcoholism | ☐ | ☐ | Epilepsy | ☐ | ☐ | Kidney Disease | ☐ | ☐ | Rheumatic Fever | ☐ | ☐ |
| Allergies | ☐ | ☐ | Glaucoma | ☐ | ☐ | Kidney Dialysis | ☐ | ☐ | Rheumatism | ☐ | ☐ |
| Anemia | ☐ | ☐ | Hay fever | ☐ | ☐ | Latex Sensitivity | ☐ | ☐ | Scarlet Fever | ☐ | ☐ |
| Arthritis | ☐ | ☐ | Head injuries | ☐ | ☐ | Lupus | ☐ | ☐ | Seizures/Fainting spells | ☐ | ☐ |
| Asthma | ☐ | ☐ | Hearing Impaired | ☐ | ☐ | Low Blood Pressure | ☐ | ☐ | Sinus Problems | ☐ | ☐ |
| Blood Disease | ☐ | ☐ | Heart Disease | ☐ | ☐ | Malignancies | ☐ | ☐ | Stomach Ulcers | ☐ | ☐ |
| Bone Disease | ☐ | ☐ | Heart Valve, Murmur | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ | Stroke | ☐ | ☐ |
| Cancer | ☐ | ☐ | Hepatitis/Liver Disease | ☐ | ☐ | Neck & Back Problems | ☐ | ☐ | Thyroid Disease | ☐ | ☐ |
| Chemical Dependency | ☐ | ☐ | Type(s) _____ | ☐ | ☐ | Nervous Problems/Disorders | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Chest Pain | ☐ | ☐ | Hepatitis Carrier | ☐ | ☐ | Pacemaker | ☐ | ☐ | Tumors or growths | ☐ | ☐ |
| Circulatory Problems | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Prosthetic Joints | ☐ | ☐ | Ulcers | ☐ | ☐ |
| Convulsions/Seizures | ☐ | ☐ | Hip or Joint replacement | ☐ | ☐ | Psychiatric Care | ☐ | ☐ | Venereal Disease | ☐ | ☐ |
| Diabetes | ☐ | ☐ | HPV | ☐ | ☐ | Radiation Treatment | ☐ | ☐ | | | |

## Medical Questions

List any medications you are taking including nonprescription drugs:

_____

_____

_____

Are you allergic to any medications? ☐ YES ☐ NO If yes, please list below:

_____

_____

Are you in good health? ☐ YES ☐ NO

Date of last medical exam:

Have you ever been hospitalized? ☐ YES ☐ NO If yes, what was the problem

_____

_____

Do you have any disease/problem you think we should know about? ☐ YES ☐ NO

_____

_____

_____

_____

Have you had a transplant operation that has depressed your immune system? ☐ YES ☐ NO

Have you had an allergic reaction to Bananas? ☐ YES ☐ NO

Do you smoke or chew tobacco? ☐ YES ☐ NO

Have you had Heart Surgery? ☐ YES ☐ NO

Are you now under the care of an MD? ☐ YES ☐ NO

Are you taking or have you ever taken bisphosphonates? (Fosamax or Actonel for osteoporosis, chemotherapy, etc.) ☐ YES ☐ NO

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**FOR WOMEN ONLY:**

Are you taking birth control pills? ☐ YES ☐ NO

Are you pregnant? ☐ YES ☐ NO Expected delivery date: _____

Are you nursing/breastfeeding? ☐ YES ☐ NO

Is there a possibility of pregnancy? ☐ YES ☐ NO

**NOTE:** Antibiotics (such as penicillin) may alter the effect cf birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

Date:

## Dental History Information

Date of last dental visit? _____

Name of your previous dentist. _____

Reason for today's visit? _____

Have you ever had an oral cancer screening? ☐ YES ☐ NO

How often do you floss your teeth? _____

Do your gums bleed when you brush? ☐ YES ☐ NO

Have you or a family member ever been treated for periodontal disease? ☐ YES ☐ NO

Have you ever had complications from an extraction? ☐ YES ☐ NO

Have you ever had a popping or clicking near your ear when you chew? ☐ YES ☐ NO

Are you prone to frequent headaches? ☐ YES ☐ NO

Do you grind or clench your teeth? ☐ YES ☐ NO

Do you have sores, blisters or swelling on your gums lips or cheeks? ☐ YES ☐ NO

Have you ever had orthodontic treatment? ☐ YES ☐ NO

Dr. Signature:

Do you snore? ☐ YES ☐ NO

Do you have problems with bad breath? ☐ YES ☐ NO

Have you ever had an allergic reactions to a crown, metal filling or dental appliance? ☐ YES ☐ NO

Have you ever used an electric toothbrush? ☐ YES ☐ NO

Are your teeth sensitive to hot, cold or pressure? ☐ YES ☐ NO

On a scale from 1 to 10, with 10 being the highest, how important is your dental health to you?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

If you could change something about your smile what would it be:

- ☐ Whiter
- ☐ Straighter
- ☐ Close Space
- ☐ Replace Black Mercury Filling with Tooth Colored Restorations
- ☐ Repair Chipped Teeth
- ☐ Replace Missing Teeth
- ☐ Less Gums Showing
- ☐ Replace Old Crowns or Caps That Don't Match

Date:

## Patient Interests

Which of these dental services are you interested in finding out more about?

- ☐ Cosmetic Dentistry
- ☐ Teeth Whitening
- ☐ Dentures
- ☐ Dental Implants
- ☐ Invisalign
- ☐ Sleep Apnea Treatment
- ☐ Gum Treatments / Gum Disease Prevention
- ☐ Root Canal Therapy
- ☐ Children's Dentistry
- ☐ Other _____

I certify that I have read and understand the questions, above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of this form.

Adult/Guardian: I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor.

Reviewed by:

**Patient:** _____ **Date:** _____

**Parent/Guardian (if patient is a minor):** _____ **Date:** _____

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☐ I would like to sign up to receive email updates from Pinnacle Dental Group, including exclusive special offers, monthly giveaways, and office newsletter