PINE RIDGE DENTAL

Thank you for selecting our Dental Healthcare Team!

We strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

PATIENT INFORMATION *(confidential)*

Name: _____ Preferred Name: _____

Birth Date: _____ / _____ / _____ SSN: _____ - _____ - _____ Email: _____

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

Phone: (Home) _____ (Work) _____ (Cell) _____

Check Appropriate Box: ❑ Minor: Parent's Name: _____

❑ Married: Spouse's Name: _____

❑ Single

If Student, Name of School/College: _____

City: _____ State: _____ ❑ Full Time ❑ Part Time

Whom may we thank for referring you? _____

Person to contact in case of emergency? Name: _____ Phone: _____

Do you have dental insurance? ❑ NO ❑ YES *(If YES, please give card to receptionist to copy.)*

Do you have any additional insurance? ❑ NO ❑ YES *(If YES, please give card to receptionist to copy.)*

PATIENT MEDICAL/ DENTAL HISTORY

Physician: _____ Phone: _____ Date of last exam: _____

Previous Dentist: _____ Location: _____ Date of last exam: _____

MEDICAL *(Circle Y for YES or N for NO.)*

Y N Are you under medical treatment now?

Y N Do you use alcohol?

Y N Do you use tobacco? *If yes circle which apply:*
cigarettes cigars chewing tobacco vape

Y N Have you ever received treatment for controlled substance abuse?

Y N Are you currently taking any medication, drugs, pills, herbal remedies, non-prescription medication or regular dosages of aspirin?
If yes, please give name(s) and dosage:
_____
_____
_____

Y N Have you ever taken prescription medication for weight loss (diet Pills)? If yes, did you take any of the following? *If yes circle which apply:*
Fen-Phen Pondimen Redux other

Y N Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva, or other similar drugs?

Y N Have you been hospitalized for any surgical operation or serious illness within the last 5 years?
When _____
What for _____

Y N Have you had a study for sleep apnea done?

Y N How many sugared or no calorie sweetened beverages (soda, energy drinks, juice. flavored water, etc.) do you consume per week?
Circle: 0-10 10-25 over 25 ❑ diet ❑ sugar

Y N What kind of water do you generally consume?
Circle One: well city bottled

Y N If well or bottled have you had your water tested for fluoride?

Do you have any of the following:

Y N Low Blood Pressure
Y N Diabetes
Y N High Blood Pressure
Y N Kidney Disease
Y N Heart Attack
Y N AIDS or HIV (positive)
Y N Thyroid Problem
Y N Heart Disease
Y N Frequently Tired
Y N Cardiac Pacemaker
Y N Anemia
Y N Arthritis
Y N Angina
Y N Eating Disorder
Y N Chest Pains
Y N Joint Replacement: If Yes, Which Joint? _____
When _____

Continue on to the back side.

Y N Easily Winded
Y N Stroke
Y N Hepatitis *Circle Please :* A B C
Y N Rheumatic Fever
Y N Stomach Troubles/Ulcers
Y N Mitral Valve Prolapse
Y N Seasonal Allergies
Y N Heart Murmur
Y N Glaucoma
Y N Swollen Ankles
Y N Liver Disease
Y N Fainting/Seizures
Y N Tuberculosis
Y N Epilepsy/Convulsions
Y N Respiratory Problems
Y N Leukemia When? _____
Y N Emphysema
Y N Asthma
Y N Cancer When? _____
Y N COPD
Y N Sickle Cell Disease
Y N Chemotherapy: When?_____
Y N Hemophilia
Y N Radiation Therapy: When? _____
Y N Other_____

Do you have or have you had any disease, condition, or problem not listed? *If yes, please list:* _____

_____

Are you allergic to or have you had any reactions to the following?

Y N Local Anesthetics (e.g. novocaine)
Y N Penicillin
Y N Sulfa Drugs **Y N** Wheat
Y N Barbiturates **Y N** Red Dye
Y N Sedatives
Y N Iodine
Y N Codeine
Y N Aspirin
Y N Any metals (e.g. nickel, etc.)
Y N Latex rubber
Y N Other_____

DENTAL

Y N Do your gums bleed while brushing or flossing?

Y N Are your teeth sensitive to hot or cold liquids or foods?

Y N Do you feel pain in any of your teeth?

Y N Do you have any sores or lumps in or near your mouth?

Y N Have you had prolonged bleeding after extractions?

Y N Do you bite your lips or cheeks frequently?

Y N Have you had orthodontic treatment before?

Y N Do you wear dentures or partials?

If YES circle which: dentures partials

If YES date of placement: _____

Y N Have you received oral hygiene instructions regarding the care of your teeth and gums?

Y N Have you had frequent ear problems?

Y N Do you have sleep apnea? *If YES circle:* diagnosed undiagnosed

Y N Do you wear a CPAP at night?

Y N Do you like your smile?

Y N Have you ever had your teeth ground or the bite adjusted?

Y N Have you ever had a bite plate or mouth guard?
Y N Are you happy with how your teeth look?
Y N Are you happy with how your teeth function?
Y N Would you like to keep all of your teeth all of your life?

Y N Do you feel nervous about dental treatment?
If YES what concerns you the most? _____

_____

_____

Women only:

Y N Are you or think you may be pregnant?
Y N Are you nursing?
Y N Are you taking oral contraceptive?

AUTHORIZATION AND RELEASE

❑ **YES** ❑ **NO** I authorize the use of my radiographs and/or photographs for professional seminars or publications of Pine Ridge Dental.

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information, including the diagnosis and the record of any treatment or examinations rendered to me or my child during the period of such Dental Care, to third party payers and or health practitioners. I authorize and request my insurance to pay directly to the dentist or dental group the insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependants.

_____ _____

Signature of patient (Parent or Guardian if patient is a minor) *Date*