Welcome to Pine Cove Dental

Our mission is to provide you and your family the best and most compassionate dental care possible. We believe in building great relationships and treating you as a person and not just another set of teeth to clean or fix. Please fill out this form completely so that we can get to know you better. Thank you for trusting us with your dental care.

Patient Information

Patient Name: _____ Date:_____
Last First MI Preferred Name

☐ Male ☐ Female ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Social Security #: _____ DOB:_____Email:_____

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

Your Address:_____
Street City State Zip

Employer Name: _____ Occupation:_____

Emergency Contact:_____ Phone:_____ Relation:_____

Health Information

Have you ever had any of the following? Please check those that apply:

☐ Allergies to:_____
- ☐ Aspirin
- ☐ Codeine
- ☐ Sulfa Drugs
- ☐ Erythromycin
- ☐ Jewelry / Metals
- ☐ Latex
- ☐ Penicillin
- ☐ Tetracycline

Other_____
_____

☐ Anemia
☐ Arthritis
☐ Artificial Joints/Valves
☐ Asthma
☐ Blood Transfusion
☐ Cancer/Chemotherapy
☐ Diabetes
☐ Dental Anxiety
☐ Epilepsy / Seizures
☐ Emphysema
☐ Excessive Bleeding
☐ Fever Blisters/ Herpes
☐ Glaucoma
☐ Heart Attack / Stroke
☐ Heart Murmur
☐ Heart Surgery/Pacemaker
☐ Hepatitis
☐ High/Low Blood Pressure
☐ HIV / AIDS
☐ Hospitalization
☐ Jaundice
☐ Kidney Problems
☐ Liver Problems
☐ Mitral Valve Prolapse
☐ Nervous Disorders
☐ Psychiatric Care
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Severe Headaches
☐ Sickle Cell Disease
☐ Sinus Problems
☐ Sleep Apnea
☐ Snoring
☐ Current Smoker/Dipper
☐ Tuberculosis (TB)
☐ Tumors
☐ Ulcers / Colitis
☐ Venereal Disease
☐ OTHER:_____
☐ OTHER:_____

WOMEN: Are you pregnant?

☐No ☐Yes #of Weeks____

- Do you have any health problems that need clarification? ☐ Yes ☐ No If yes, please explain: _____

_____

- Do you require antibiotic premedication ☐ Yes ☐ No
- Name of Physician: _____ Phone:_____
- Are you now under the care of a physician? ☐ Yes ☐ No If yes, please explain:

_____

- Please list **any** prescription, over-the-counter drugs, vitamins, or herbal supplements you are taking: _____

_____

- How did you about our practice? ☐ Another patient, friend, or relative ☐ Dental Office ☐ Internet ☐ School ☐ Yellow Pages ☐ Newspaper / Magazine ☐ Work ☐ Other_____

Whom may we thank for referring you to our practice? _____
(Name of person or office referring you to our practice)

- What are your personal interests or hobbies? _____
- Is there anything or anyone you would like to add to our prayer list? _____

_____ _____
Signature of patient, parent or guardian Date Dentist Signature – Pine Cove Dental

Dental Information

Why have you come to the dentist today? _____

☐ Yes ☐ No Has your doctor ever told you that you require antibiotics before dental treatment?
☐ Yes ☐ No Have your ever had a serious / difficult problem associated with any previous dental work?
☐ Yes ☐ No Do you have, or have you ever experienced pain /discomfort in your jaw joint (TMJ / TMD)?
☐ Yes ☐ No Are you currently having dental pain?
☐ Yes ☐ No Have you ever had a toothache?
☐ Yes ☐ No Have you ever fractured or cracked a tooth?
☐ Yes ☐ No Are you concerned about your silver / mercury fillings?
☐ Yes ☐ No Have you noticed spots, stains, or chips on your teeth that concern you?
_____ On a scale of 1 -10 (with a 10 being BEST), how would you rate your smile?
☐ Yes ☐ No Have you ever considered whitening your teeth?
☐ Yes ☐ No Have you ever considered straightening your teeth?
☐ Yes ☐ No Do you have any place where food gets trapped between your teeth or areas that are difficult to floss?
☐ Yes ☐ No Have you ever been told that you have, or have you ever been treated for, gum disease (periodontitis)?
☐ Yes ☐ No Would you like to keep your teeth for the rest of your life?

How many times a day do you brush your teeth? ____ What do you use to clean between your teeth? _____

How would you rate your dental health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of last cleaning/exam:_____ Previous Dentist: _____ City: _____

What did you like most about any dentist you have seen?_____Least ?_____

Why did you leave your previous dentist? _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ DOB: _____ SSN: _____

Address: _____

Phone (Home): _____ (Cell): _____

Employer Name: _____ Work Phone:_____

Relationship to Patient: _____

Insurance Information

Name of Insured: _____DOB: _____ SSN: _____

Insured's Address:_____ Phone: _____

Insured's Employer Name: _____ Phone: _____

Insurance Company Name: _____ Phone: _____

Group #: _____ Insured's ID #: _____

Consent for Services

With my signature below, I authorize:

- The dental staff of Pine Cove Dental to perform any necessary dental services required during my diagnosis and treatment, with my informed consent.
- The use of photographs of myself and my dental treatment in scientific articles, publications, and/or presentations.
- The release of any information necessary to process insurance claims.
- If I request payment arrangements for services rendered, the generation of a credit report/inquiry.

_____ _____ _____

Printed Name Signature of patient, parent or guardian Date