Patient Information Form **Date:**_____

Pine Street DENTAL

Patient Information:

Patient Name:_____
Last First MI (Preferred Name)

Social Security #: _____ Birth Date: _____ Gender:_____

Mailing Address:_____
Street / P.O. Box Apartment

City:_____ State:_____ Zip Code:_____

Home #: _____ Cell #:_____ Work #:_____ Ext:_____

Email:_____ **Preferred Method of Communication: Text ___ Email ___ Cell# ___ Home#___**

Employed By:_____ **Do you have dental insurance through this company?:** ☐Y ☐N

If Yes, Name of dental Insurance:_____ I.D. #:_____Group #:_____

Address of Insurance:_____

Parent/Spouse Information: (Not Applicable ☐)

Parent/Spouse Name:_____ Birth Date:_____ S.S. #:_____

Address(if different):_____
Street City State Zip Code

Home #: _____ Cell #: _____ Work #: _____

Email Address:_____

Parent/Spouse Employed By:_____ **Do you have dental insurance through this company?:** ☐Y ☐N

If Yes, Name of Insurance:_____I.D. #:_____ Group #:_____

Address of Insurance:_____

Whom shall we contact in case of an emergency?: Name:_____

Relationship:_____ Home #:_____Cell #:_____

HIPAA Authorization: Whom do you authorize Pine Street Dental to speak with regarding your dental, financial and appointment information:

Name(s):_____ Best Phone #:_____

_____ _____

Are we able to leave detailed messages on your voicemail/answering machine? ☐Y ☐N

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian:_____ **Date:** _____

Patient Name:_____ **Date:**_____

Pine Street DENTAL

Patient Health History:

Primary Physicians Name: _____ Physicians Phone:_____

Are you allergic to any of the following (please circle all that apply): ☐ Yes ☐ No

Penicillin Tetracycline Sulfa Drugs Aspirin Codeine Latex Metals Dental Anesthetics Other_____

Have you ever had any of the following? Please answer Yes or No to each question by marking the boxes below.

Y N		Y N		Y N		Y N	
☐ ☐	Heart Murmur	☐ ☐	Respiratory Disease	☐ ☐	Mitral Valve Prolapse	☐ ☐	Dizziness/Fainting
☐ ☐	Heart Disease	☐ ☐	Asthma	☐ ☐	Growths/Tumors	☐ ☐	Epilepsy/Seizures
☐ ☐	High Blood Pressure	☐ ☐	Hay Fever	☐ ☐	Chemotherapy	☐ ☐	Mental Disorders
☐ ☐	Low Blood Pressure	☐ ☐	Allergies	☐ ☐	Radiation Treatment	☐ ☐	Nervous Disorders/Anxiety
☐ ☐	Stroke	☐ ☐	Sinus Trouble	☐ ☐	Jaundice	☐ ☐	Eating Disorders
☐ ☐	Artificial Heart Valve	☐ ☐	Diabetes Type:_____	☐ ☐	Kidney Disease	☐ ☐	Drug/Alcohol Addiction
☐ ☐	Pacemaker	☐ ☐	Blood Disease/Disorder	☐ ☐	Liver Disease	☐ ☐	Head Injuries
☐ ☐	Blood Transfusion	☐ ☐	HIV/AIDS	☐ ☐	Menopause	☐ ☐	Frequent Headaches
☐ ☐	High Cholesterol	☐ ☐	Herpes Lesions	☐ ☐	Arthritis Type:_____	☐ ☐	Acid Reflux/GERD
☐ ☐	Bruise Easily	☐ ☐	Ulcers	☐ ☐	Excessive Bleeding	☐ ☐	Hepatitis Type:_____
☐ ☐	Anemia	☐ ☐	Glaucoma	☐ ☐	Thyroid Type:_____	☐ ☐	HPV Virus
☐ ☐	Cold Sores	☐ ☐	Cortisone Treatment	☐ ☐	Chest Pain	☐ ☐	Sleep Apnea
☐ ☐	Lyme Disease	☐ ☐	Migraines				

Joint Replacement: ☐Y ☐N Type:_____ Date: _____ **Pre-Med Required:** ☐Y ☐N

Cancer: ☐Y ☐N Type:_____ Date:_____ Chemotherapy: ☐Y ☐N Radiation: ☐Y ☐N

Do you have any other health problems or conditions? ☐YES ☐NO

If yes, please explain: _____

Are you taking any medications or vitamins/supplements at this time? ☐YES ☐NO

If yes, please list medications/supplements below:

_____ _____

_____ _____

_____ _____

_____ _____

Consent to view medications prescribed by other physicians? ☐ YES ☐ NO

Have you been admitted to a hospital or needed emergency care during the past year? ☐YES ☐NO

If yes, please explain: _____

Are you now under the care of a specialist? ☐YES ☐NO Name of Physician: _____

Do you smoke/use tobacco products? ☐YES ☐NO Type:_____ How much per day?:_____

WOMEN: (Male/Not Applicable)☐

Are you pregnant or nursing? ☐YES ☐NO Due Date: _____ **Are you taking birth control?** ☐YES ☐NO

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian:_____ **Date:** _____

Doctor Signature:_____ **Date:**_____ **Date Reviewed:**_____ **Date Reviewed:**_____