



Christopher J. MacKnight, DDS
Thomas N. Tetrick, DDS
Fariba Vakilzadian, DDS
Richard S. Nolte, DDS
Joshua P. King, DDS
Brent E. Murphy, DDS

ADULT FORM

EDGEWOOD: 5140 S. 56TH STREET • LINCOLN, NEBRASKA 68516
 WILDERNESS RIDGE: 8545 EXECUTIVE WOODS DRIVE • LINCOLN, NEBRASKA 68512

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

Patient name _____ Today's Date _____
Last First MI

I prefer to be called _____ Male Female

Referred to Pine Ridge Dental through _____

Birthdate _____ Age _____ Social Security Number _____
 Single Divorced Married Widowed Separated

Please check preferred mode(s) of contact:

Home phone _____ Work phone _____ Ext _____ Mobile phone _____

Text messaging _____ E-mail _____ May we call you at work if needed? Yes No

Home address _____
Street City State Zip

Mailing address, if different _____

Employer _____ Occupation _____

Person financially responsible for your account, if not self _____

Billing address _____ Relationship _____

Person, outside the home, to contact in case of emergency _____ Phone _____

DENTAL INSURANCE

Do you carry your own dental insurance? Yes No

Secondary Insurance coverage is through

If no, who is the coverage through Parent Other _____

Parent Other _____

Primary Insurance Holder's Name _____

Secondary Ins. Holder's Name _____

Primary Ins. Holder's Birthdate _____

Secondary Ins. Holder's Birthdate _____

Primary Ins. Holder's Social Security # _____

Secondary Ins. Holder's Social Security # _____

Primary Ins. Holder's Employer _____

Secondary Ins. Holder's Employer _____

Primary Ins. Holder's Insurance Co. _____

Secondary Ins. Holder's Insurance Co. _____

Subscriber ID# _____

Subscriber ID# _____

Please take the time to fill out medical history on reverse

MEDICAL HISTORY

Do you have a personal physician? Yes No

Name _____ Phone _____

Approximate date of your last doctor visit _____

Are you currently under the care of any physician? Yes No

If yes, please explain _____

Are you presently taking any medications prescribed by a physician or dentist?

Yes No If yes, please list or attach on a separate sheet.

Are you presently taking, or have you ever taken, any of the following bisphosphonate drugs to treat bone disorders including osteoporosis?

- Actonel (risedronate) Aredia (pamidronate) Boniva (ibandronate)
 Didronel (etidronate) Fosamax (alendronate)
 Skelid (tiludronate disodium) Zometa/Reclast (zoledronate)

For women, are you pregnant? Possibly Yes No If yes, Week # _____

Do you need to be premedicated with antibiotics before dental treatment?

Yes No (This is to prevent bacterial endocarditis after joint replacement or due to congenital heart disease, prosthetic heart valves or other heart conditions; final confirmation of the need for premedication should be made by your physician).

Have you had any serious medical problems in the last 5 years? Yes No

If yes, please explain _____

Check box if you have you had any history of, or conditions related to, any of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Heart valve disease | <input type="checkbox"/> Prosthetic heart valve |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Infective endocarditis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> HIV+/AIDS | <input type="checkbox"/> Chronic hepatitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> TMJ (jaw) pain/TMD | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Tobacco use, <i>how much?</i> _____ |
| <input type="checkbox"/> Hemophilia/bleeding | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Drug/alcohol abuse |
| <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Chemo/Radiation | <input type="checkbox"/> Dental anxiety |
| <input type="checkbox"/> Xerostomia/dry mouth | <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Psychiatric disorders | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Chronic sinus problems | <input type="checkbox"/> Anemia | <input type="checkbox"/> Hyperthyroid |
| <input type="checkbox"/> Asthma/respiratory problems | <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Human papilloma virus | <input type="checkbox"/> Fever blisters/cold sores | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Transplant | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Sight problems | <input type="checkbox"/> Fibromyalgia | |

Have you experienced any other serious conditions that are not listed above?

Yes No If yes, please list _____

Are you allergic to any of the following?

- | | | |
|---|---|---|
| <input type="checkbox"/> Penicillin/Amoxicillin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Dental anesthetics |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Sulfur | <input type="checkbox"/> Cephalosporins | <input type="checkbox"/> Clindamycin |
| <input type="checkbox"/> Jewelry/Nickel | <input type="checkbox"/> Latex | <input type="checkbox"/> Other, please list _____ |

DENTAL HISTORY

Why have you come to the dentist today? _____

How long since your last dental visit? _____

When were your teeth last cleaned? _____

Do you have your wisdom teeth? Yes No Don't know

Are you currently in pain? Yes No

Do you experience dental anxiety? Yes No

Do you clench or grind your teeth? Yes No

Do you like your smile? Yes No If no, what would you like to change? _____

Have you had complications or difficulties with previous dental treatment? Yes No

If yes, please explain _____

If you have dental insurance, do you let the insurance dictate what treatment you should receive? Yes No

Do you have suggestions on how Pine Ridge Dental can best meet your needs?

Yes No If yes, please explain _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

24 hour cancellation notice required or charge will be made.

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes.

Patient Signature _____

Date _____

OFFICE USE ONLY Doctor's comments _____