ADULT FORM

Pine Ridge Dental
5140 S. 56th St. Lincoln, NE 68516 ● 8545 Executive Woods Dr. Lincoln, NE 68512
Phone: 402.423.1100 ● Fax: 402.423.1368 ● www.pineridgedental.com

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:_____

Name preference:_____ ☐ Male ☐ Female

Referred to Pine Ridge Dental through:_____

Birthdate:_____ Age:_____ SSN:_____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please Check preferred mode(s) of contact:

☐ Cell Phone:_____ ☐ Home Phone:_____ ☐ Work phone:_____
☐ Call ☐ Text May we call you at work? ☐Yes ☐No

☐ E-mail:_____

Home Address:_____
Street City State Zip

Employer: _____ Occupation: _____

Person financially Responsible, if not self: _____ Relationship: _____

Billing Address: _____
Street City State Zip

Emergency Contact:_____ Relationship:_____ Phone:_____

Medical Information

Are you now under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

_____

Physician Name:_____ Phone: _____

Date of last physical exam:_____

Are you currently taking any medications?
☐ 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 bisphosphonates drugs to treat bone disorders including osteoporosis?

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

For women, are you pregnant? ☐ Possibly ☐ Yes ☐ No If yes, week#: _

Do you need to be pre-medicated with antibiotics before dental treatment? ☐ Yes ☐ No What is the Pre-Med for?_____

Have you had serious illness, operation or been hospitalized in the past 5 years? If yes, what was the illness or problem? ☐ Yes ☐ No
If yes please explain _____

_____

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

☐ Anemia
☐ Arthritis
☐ Asthma/Respiratory problems
☐ Atrial Fibrillation
☐ Chronic sinus problems
☐ Cancer/Tumors
☐ Congenital heart disease
☐ Chronic Hepatitis
☐ Chemo/Radiation
☐ Diabetes
☐ Drug/Alcohol abuse
☐ Dental Anxiety
☐ Epilepsy/Seizures
☐ Fainting spells
☐ Fever blister/cold sores
☐ Fibromyalgia
☐ Hearing problems
☐ Heart attack
☐ Heart surgery
☐ Heart valve Disease
☐ Hemophilia /bleeding
☐ HIV+/AIDS
☐ High Blood Pressure
☐ Human papilloma virus
☐ Hyperthyroid
Hypothyroid
☐ Infective endocarditis
☐ Joint replacement
☐ Kidney disease
☐ Liver disease
☐ Low blood pressure
☐ Pacemaker
☐ Prosthetic heart valve
☐ Psychiatric disorders
☐ Shingles
☐ Sickle cell disease
☐ Sight problems
☐ Stroke
☐ TMJ/Jaw pain/TMD
☐ Tobacco use, how much?__
☐ Transplant
☐ Tuberculosis
☐ NONE

Have you experienced any other serious conditions that are not listed above? ☐ Yes ☐ No If yes, please list: _____

_____

Allergies:

☐Penicillin/Amoxicillin
☐Aspirin
☐Sulfa drugs
☐jewelry/Nickel
☐Erythromycin
☐Tetracycline
☐Cephalosporins
☐Latex (rubber)
☐Sulfur drugs
☐Dental anesthetics
☐Codeine
☐Clindamycin
☐Other, please list

_____

_____

Dental Information

Why have you come to the dentist today?

_____

_____

Date of your last dental visit: _____

When were your teeth last cleaned: _____

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

Are you currently experiencing dental 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 complication 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: _____

_____

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:_____

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

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.

OFFICE USE ONLY Doctor's Comments:

_____

_____

_____