4131 Pioneer Woods Dr., Suite 101, Lincoln, NE 68506 || P. 402-489-3453 || F. 402-488-1119

Dentistry at Pioneer Woods

Today's Date_____

How did you hear about us? (Name of patient if referral)_____

Patient Information

Last Name:_____ First Name:_____ Middle Initial:_____

Address:_____ City:_____ ST:____ Zip:_____

Home Phone:_____ Mobile Phone:_____

Employer:_____ Work Phone:_____

Email:_____

Marital Status:_____ Sex: M F Birth Date:_____ Social Security #:_____

Emergency Contact Name:_____ Emergency Contact Number:_____

Responsible Party (If patient is under 19)

Last Name:_____ First Name:_____ DOB:_____

Address:_____ City:_____ ST:____ Zip:_____

Relation to Patient:_____

Home Phone:_____ Work Phone:_____Mobile Phone:_____

Dental Insurance Information

Name of Insured:_____ Relationship to Patient:_____

Policy Holder's Social Security #:_____ Policy Holder's Date of Birth:_____

Name of Insured's Employer:_____ Phone # of Employer:_____

Insurance Company:_____ Policy Number:_____ Group #:_____

Secondary Insurance: Y / N _____

Submit

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Medical History

Patient Name:_____ Birth Date:_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ❍ Yes ❍ No If yes, please explain:_____
Physician's name_____ Phone_____
Have you ever been hospitalized or had a major operation? ❍ Yes ❍ No If yes, please explain:_____
Have you ever had a serious head or neck injury? ❍ Yes ❍ No If yes, please explain:_____
Are you taking any medications, pills, or drugs? ❍ Yes ❍ No If yes, please explain:_____
Do you take, or have you taken, Phen-Fen or Redux? ❍ Yes ❍ No
Are you on a special diet? ❍ Yes ❍ No
Describe your current physical health. ❍ Good ❍ Fair ❍ Poor
Do you use tobacco? ❍ Yes ❍ No
Do you use a controlled substance? ❍ Yes ❍ No

Women: Are you pregnant/trying to get pregnant? ❍ Yes ❍ No Taking oral contraceptives? ❍ Yes ❍ No Nursing? ❍ Yes ❍ No

Are you allergic to any of the following?
Aspirin ❍ Penicillin ❍ Codeine ❍ Acrylic ❍ Metal ❍ Latex ❍ Local Anesthetics ❍
Other ❍ If yes, please explain_____

Dental History

Why have you come to the dentist today?_____
Are you currently in pain? ❍ Yes ❍ No
Do you require antibiotics before dental treatments? ❍ Yes ❍ No
Describe your current dental health. ❍ Good ❍ Fair ❍ Poor
Have you ever had serious/difficult problems associated with any previous dental work? ❍ Yes ❍ No
If yes, please explain_____
How many times per day do you brush?_____
How many times a week do you floss?_____
Type of bristles on your toothbrush. ❍ Hard ❍ Medium ❍ Soft
Have you ever had gum treatment? ❍ Yes ❍ No
Do your gums ever bleed? ❍ Yes ❍ No
Have you ever had periodontal disease? (gum disease) ❍ Yes ❍ No
Do you now or have you ever experienced pain/discomfort in your jaw joint? (TMJ/TMD) ❍ Yes ❍ No
Are your teeth sensitive to heat, cold, or anything else? ❍ Yes ❍ No
Do you have any loose teeth? ❍ Yes ❍ No
Do you still have wisdom teeth? ❍ Yes ❍ No
Would you like whiter teeth? ❍ Yes ❍ No
Are you happy with your smile? ❍ Yes ❍ No
If no, what would you change?_____

To the best of my knowledge, all of the preceding answers are true and correct. I will inform the dental staff at the next appointment if I ever have any change in my health, or if my medications change.

_____ _____
Signature of Patient, Parent, or Guardian Date

Submit

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Do you have any of the following?

Abnormal Bleeding/Hemophilia	❍ Yes ❍ No	Hemophilia	❍ Yes ❍ No
AIDS/HIV Positive	❍ Yes ❍ No	Hepatitis A	❍ Yes ❍ No
Alcohol/Drug Abuse	❍ Yes ❍ No	Hepatitis B or C	❍ Yes ❍ No
Alzheimer's Disease	❍ Yes ❍ No	Herpes	❍ Yes ❍ No
Anaphylaxis	❍ Yes ❍ No	High Blood Pressure	❍ Yes ❍ No
Anemia	❍ Yes ❍ No	Hives or Rash	❍ Yes ❍ No
Angina	❍ Yes ❍ No	Hypoglycemia	❍ Yes ❍ No
Arthritis/Gout	❍ Yes ❍ No	Irregular Heartbeat	❍ Yes ❍ No
Artificial Bones/Joints/Valves	❍ Yes ❍ No	Kidney Problems	❍ Yes ❍ No
Asthma	❍ Yes ❍ No	Leukemia	❍ Yes ❍ No
Blood Disease	❍ Yes ❍ No	Liver Disease	❍ Yes ❍ No
Blood Transfusion	❍ Yes ❍ No	Low Blood Pressure	❍ Yes ❍ No
Breathing Problems	❍ Yes ❍ No	Lung Disease	❍ Yes ❍ No
Bruise Easily	❍ Yes ❍ No	Lupus	❍ Yes ❍ No
Cancer	❍ Yes ❍ No	Mitral Valve Prolapse	❍ Yes ❍ No
Chemotherapy	❍ Yes ❍ No	Pain in Jaw Joints	❍ Yes ❍ No
Chest Pains	❍ Yes ❍ No	Parathyroid Disease	❍ Yes ❍ No
Cold Sores/Fever Blisters	❍ Yes ❍ No	Psychiatric Care	❍ Yes ❍ No
Colitis	❍ Yes ❍ No	Radiation Treatment	❍ Yes ❍ No
Congenital Heart Disorder	❍ Yes ❍ No	Recent Weight Loss	❍ Yes ❍ No
Convulsions	❍ Yes ❍ No	Renal Dialysis	❍ Yes ❍ No
Cortisone Medicine	❍ Yes ❍ No	Rheumatic Fever	❍ Yes ❍ No
Diabetes	❍ Yes ❍ No	Rheumatism	❍ Yes ❍ No
Easily Winded	❍ Yes ❍ No	Scarlet Fever	❍ Yes ❍ No
Emphysema	❍ Yes ❍ No	Shingles	❍ Yes ❍ No
Epilepsy or Seizures	❍ Yes ❍ No	Sickle Cell Disease	❍ Yes ❍ No
Excessive Bleeding	❍ Yes ❍ No	Sinus Trouble	❍ Yes ❍ No
Excessive Thirst	❍ Yes ❍ No	Spina Bifida	❍ Yes ❍ No
Fainting Spells	❍ Yes ❍ No	Stomach/Intestinal Disease	❍ Yes ❍ No
Frequent Cough	❍ Yes ❍ No	Stroke	❍ Yes ❍ No
Frequent Diarrhea	❍ Yes ❍ No	Swelling of Limbs	❍ Yes ❍ No
Frequent Headaches	❍ Yes ❍ No	Thyroid Disease	❍ Yes ❍ No
Genital Herpes	❍ Yes ❍ No	Tonsillitis	❍ Yes ❍ No
Glaucoma	❍ Yes ❍ No	Tuberculosis	❍ Yes ❍ No
Hay Fever	❍ Yes ❍ No	Tumors or Growths	❍ Yes ❍ No
Heart Attack/Failure	❍ Yes ❍ No	Ulcers	❍ Yes ❍ No
Heart Murmur	❍ Yes ❍ No	Venereal Disease	❍ Yes ❍ No
Heart Pacemaker	❍ Yes ❍ No	Yellow Jaundice	❍ Yes ❍ No
Heart Trouble/Disease	❍ Yes ❍ No	Other_____	

To the best of my knowledge, all of the preceding answers are true and correct. I will inform the dental staff at the next appointment if I ever have any change in my health, or if my medications change.

_____ _____

Signature of Patient, Parent, or Guardian Date

Submit