Pinnacle Peak Dental Care
Jordyn & Taylor Family Dental , PLLC

8900 E. Pinnacle Peak Rd. Suite D-210 • Scottsdale, AZ 85255
Office | (480) 659-9499 • Fax | (480) 659-3609 • Email | info@pinnaclepeakdental.com

PATIENT INFORMATION FORM

Welcome!

The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach and maintain maximum oral health.

PLEASE FILL OUT THIS FORM COMPLETELY.

The better we communicate,
the better we can care for you.

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1 About You

PATIENT INFORMATION

First Name _____ **Middle Initial** _____ **Last Name** _____

Address _____ apt./unit/ste _____

City _____ State _____ Zip _____

Home# _____ **Work#** _____ **Mobile#** _____

Birthdate / / **SS#** _____ **Drivers Lic.** _____

☐ I would like to receive correspondences via e-mail **Email Address** _____

RESPONSIBLE PARTY (If someone other than the patient)

First Name _____ **Middle Initial** _____ **Last Name** _____

Address _____ apt./unit/ste _____

City _____ State _____ Zip _____

Home# _____ Work# _____ Mobile# _____

Birthdate / / SS# _____ Drivers Lic. _____

☐ Responsible Party is also Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

REFERRED BY: _____

EMERGENCY CONTACT:

Contact Name _____ Phone# _____

Relationship _____

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2 Employment

Employment Status ☐ Full Time ☐ Part Time ☐ Retired Student Status ☐ Full Time ☐ Part Time ☐ Retired

Employer _____ School Name _____

3 Insurance

PRIMARY INSURANCE

Name of Insured _____ Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured SS# or ID _____ Birth Date _____

Address _____ Insurance Co. _____

City _____ Insurance Phone Number _____

State _____ Zip _____ Employer _____

4 Medical History

Are you under a physician's care now?	☐ Yes ☐ No	If Yes, please explain _____
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	If Yes, please explain _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes ☐ No	If Yes, please explain _____
Are you on a special diet?	☐ Yes ☐ No	If Yes, please explain _____
Do you use tobacco?	☐ Yes ☐ No	
Do you use controlled substances?	☐ Yes ☐ No	

FOR WOMEN

Pregnant / Trying to get pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Taking oral contraceptives? ☐ Yes ☐ No If yes, _____

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ALLERGIES

Are you allergic to any of the following:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ OTHER, Explain _____

Do you have, or have you had, any of the following:

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

Have you ever had any serious illness not listed above:

☐ Yes ☐ No If Yes, please explain _____

_____

Please List All Medications:

_____

_____

_____

_____

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5 Medical Info

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name _____

Phone#_____ Last Visit Date / /

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

If yes, please explain:_____

Preferred Pharmacy:_____

Pharmacy Phone #: _____

6 Dental History

Why have you come to the dentist today?_____

_____

Has your doctor told you that you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Your current dental health is? ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you use floss?_____

How many times a day do you brush?_____

Type of toothbrush? ☐ Manual ☐ Electric

7 Disclaimer

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

In the event that payment in full for charges incurred is not made, I agree to pay off all costs of collection including a 50% collection fee, attorney fees and court costs.

Signature _____

Date _____

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

8 Privacy Practices

ACKNOWLEDGEMENT OF PRACTICE NOTICE OF PRIVACY

I, _____, understand that Pinnacle Peak Dental Care, abides by the HIPAA Law and will protect the privacy of your personal information.

_____

Please Print Name

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement for the receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign.

____ Communication barriers prohibited us from obtaining acknowledgement.

____ An emergency situation prevented us from obtaining acknowledgment.

____ Other (Please Specify)

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WELCOME PAGE - Q&A

We warmly welcome you.

To better serve you, please take just a moment to answer the following questions. Thanks!

What is the most important thing to you about your smile and dental health? _____

_____

_____

Please share the following approximate dates:

Your last cleaning _____

Your last oral cancer screening _____

Your last complete x-rays _____

Your last exam _____

Who was your previous dentist?

Name: _____

City: _____ State: _____

Phone: _____

Do you have or have you had any of the following?

☐ Dentures
☐ Partial Dentures
☐ Periodontal (gum) treatments

If you could whiten your teeth, at a cost that anyone could afford, would you like to? ☐ Yes ☐ No

Do you smoke or use chewing tobacco

☐ Yes ☐ No

If yes, how much? And, for how long?

If you could change your smile, would you:

(Please check all that apply)

☐ Have a bright white smile
☐ Make your teeth straighter
☐ Close spaces between teeth
☐ Replace silver metal fillings with tooth-colored restorations
☐ Repair chipped teeth
☐ Replace missing teeth
☐ Replace old crowns that don't match
☐ Have a smile makeover
☐ Healthy gums
☐ Fresh breath

On a scale of 1 to 5, with 5 being the highest rating:

(Please circle the number that best applies)

How important is your dental health to you?

1 2 3 4 5

How would you rate your current dental health?

1 2 3 4 5

Where do you want your dental health care to be?

1 2 3 4 5

Why did you leave your previous dentist? _____

_____

What is the most important thing to you about your dental visit today? _____

_____

Thank You!

We appreciate you for filling out this form completely.
It will allow us to serve you more effectively.
If you have a question at any time, please call us. We are happy to help.