

Welcome! Please complete this form as fully as you can. If you have any questions, our team is glad to help.

Patient Information

First Name*	Last Name*	Preferred Name	
Date of Birth*	Gender (M / F / Other / Prefer not to say)	Marital Status (Single / Married / Minor / Other)	Social Security #
Home Address*	City*	State*	Zip Code*
Primary Phone*	Secondary Phone	Email*	
Student Status (Full / Part / Non-student)	Best time to contact you	Appt. reminders via (Text / Email / Mail)	
Whom may we thank for referring you?	Other family members treated by us		

Employment Information

Employer	Occupation	Work Phone
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Emergency Contact

Name*	Relationship to Patient*	Phone*	Email Address
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Responsible Party (if patient is a minor or not self-responsible)

Name	Relationship to Patient	Date of Birth	Phone
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Dental Insurance Information

Primary Insurance

Insurance Company	Subscriber Name	Subscriber Date of Birth
Member / ID #	Group #	Patient's Relationship to Subscriber

Secondary Insurance (if applicable)

Insurance Company	Subscriber Name	Subscriber Date of Birth
Member / ID #	Group #	Patient's Relationship to Subscriber

Dental History

Date of last dental visit	Date of last dental x-rays	Previous dentist
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Reason for today's visit / chief concern

Please mark Yes or No:

☐ Y ☐ N	Do your gums bleed when brushing or flossing?	☐ Y ☐ N	Are your teeth sensitive to hot, cold, or sweets?
☐ Y ☐ N	Do you have pain or clicking in your jaw (TMJ)?	☐ Y ☐ N	Do you grind or clench your teeth?
☐ Y ☐ N	Do you have any loose, chipped, or broken teeth?	☐ Y ☐ N	Are you happy with the appearance of your smile?
☐ Y ☐ N	Do you experience bad breath or a bad taste?	☐ Y ☐ N	Have you had periodontal (gum) treatment?
☐ Y ☐ N	Do you have frequent headaches or facial pain?	☐ Y ☐ N	Is any food catching between your teeth?

Physician Name

Physician Phone

Date of last physical exam

List all medications you are currently taking

Allergies (medications, latex, foods, etc.)

Are you currently under a physician's care?

☐ Yes

☐ No

Have you ever been hospitalized or had a major operation?

☐ Yes

☐ No

Are you taking, or have you taken, any blood thinners or bisphosphonates?

☐ Yes

☐ No

Women: Are you pregnant or nursing?

☐ Yes

☐ No

☐ N/A

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

☐ Y ☐ N Heart disease / murmur

☐ Y ☐ N High or low blood pressure

☐ Y ☐ N Artificial heart valve / joint

☐ Y ☐ N Pacemaker

☐ Y ☐ N Rheumatic fever

☐ Y ☐ N Diabetes

☐ Y ☐ N Thyroid problems

☐ Y ☐ N Asthma / breathing problems

☐ Y ☐ N Tuberculosis

☐ Y ☐ N Hepatitis / liver disease

☐ Y ☐ N Kidney disease

☐ Y ☐ N HIV / AIDS

☐ Y ☐ N Cancer / tumors

☐ Y ☐ N Chemotherapy / radiation

☐ Y ☐ N Epilepsy / seizures

☐ Y ☐ N Stroke

☐ Y ☐ N Anemia / blood disorder

☐ Y ☐ N Stomach / ulcer problems

☐ Y ☐ N Arthritis

☐ Y ☐ N Anxiety / depression

☐ Y ☐ N Latex sensitivity

☐ Y ☐ N Fainting / dizziness

☐ Y ☐ N Tobacco use

☐ Y ☐ N Alcohol / substance use

Please explain any 'Yes' answers above

(continued)

Financial Responsibility

I understand that payment for dental services is due at the time services are rendered unless other arrangements have been made in advance. I understand that dental insurance is a contract between me and my insurance company, and I am financially responsible for all charges whether or not they are covered by insurance. I authorize Pinnacle Dental to release any information necessary to process my dental benefit claims.

Consent for Treatment

I authorize Dr. David S. Cannon and the staff of Pinnacle Dental to perform the dental examination, diagnostic procedures (including necessary x-rays), and treatment as agreed upon. I understand that a more definitive treatment plan will be discussed with me before treatment begins.

Notice of Privacy Practices (HIPAA) Acknowledgment

I acknowledge that I have been given the opportunity to review Pinnacle Dental's Notice of Privacy Practices, which describes how my health information may be used and disclosed. A copy is available upon request at the front desk.

Accuracy of Information

I certify that the information I have provided on this form is accurate and complete to the best of my knowledge. I will notify the practice of any changes to my health status or medical history.

Signature of Patient (or Parent/Guardian if minor)

Date

Printed Name