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PINNACLE  
IMPLANTS & PERIODONTICS

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LONGVIEW, TX 75605

**Personal Information**

Date: \_\_\_\_\_  
 Dr  Mr  Mrs  Ms  Miss  
Name: \_\_\_\_\_  
Email: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home phone: \_\_\_\_\_  
Cell phone: \_\_\_\_\_  
Work phone: \_\_\_\_\_  
Place of Employment: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
 Male  Female  Married  Single  Other

**Dental Insurance Information**

Primary Insurance Provider: \_\_\_\_\_  
Policy in the name of: \_\_\_\_\_  
Policyholder's Date of Birth: \_\_\_\_\_  
Contract #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Secondary Insurance Provider: \_\_\_\_\_  
Policy in the name of: \_\_\_\_\_  
Policyholder's Date of Birth: \_\_\_\_\_  
Contract #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Medical Insurance Information**

Primary Insurance Provider: \_\_\_\_\_  
Policy in the name of: \_\_\_\_\_  
Policyholder's Date of Birth: \_\_\_\_\_  
Contract #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Dental History**

Reason for visit: \_\_\_\_\_  
Name of Referring Dentist: \_\_\_\_\_ Date of last visit: \_\_\_\_\_ Recent X-rays:  Yes  No  
Have you ever had treatment for gum problems?  Yes  No \_\_\_\_\_

**Confidential Medical History**

Physician's name: \_\_\_\_\_ Telephone #: \_\_\_\_\_ Date of last visit: \_\_\_\_\_  
Are you under a doctor's care now?  Yes  No \_\_\_\_\_  
Have you been hospitalized in the last 5 years?  Yes  No \_\_\_\_\_  
Do you bleed excessively when cut?  Yes  No Do you smoke?  Yes  No  
Do you have allergies?  Yes  No If so, to what? \_\_\_\_\_  
Do you need to premedicate prior to dental treatment?  Yes  No  
Please list medication(s): \_\_\_\_\_  
Are you pregnant?  Yes  No Are you nursing?  Yes  No Taking birth control pills?  Yes  No  
Taking bisphosphonates?  Yes  No If yes:  Oral  IV  
Have you had or do you have any of the following? Please check all that apply:  

<input type="checkbox"/> Heart Murmur/Mitral Valve Prolapse	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Blood Disorder
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Latex Allergy	<input type="checkbox"/> Anemia
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> HIV+	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Psychiatric Care/Depression	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Malignancy	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Asthma
<input type="checkbox"/> Radiation or Chemotherapy	<input type="checkbox"/> Artificial Joints or Valves	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Digestive Disorders	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Metal Allergy	<input type="checkbox"/> Stroke	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> TMJ
<input type="checkbox"/> Chemical/Alcohol Dependency	<input type="checkbox"/> Head and Neck Pain		

  
Please indicate any other serious illness not indicated above: \_\_\_\_\_

**Informed Consent**

I have read, understood and completed accurately the above information. Further, I give permission to the doctors to use anesthetics ("Novocain") as necessary to complete my dental treatment.

Signature: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_