Pinnacle Peak
DENTAL CARE
HOLLY LERMA, DDS

8900 E. Pinnacle Peak Rd. # D210 • 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 _____

_____

COMMENTS: _____

_____

_____

_____

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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

Holly Lerma, D.D.S.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I, _____ , understand that Dr. Lerma's Office 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.