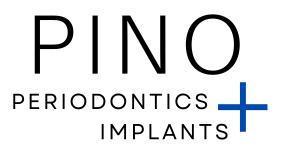
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Curtis M. Pino DDS, MSD 7007 Wyoming Blvd. NE Ste D-1 Mailing: PO BOX 94598 Albuquerque, NM 87109

Reason for Visit:			Referring Dentist:			
	mission our office will sho r referring dentist(s). Ple	•	·		h	
PATIENT INFORMAT	ΠON					
Patient name:			Mr. Mrs. Dr. Ms. Miss.	Date of birth:	Gender:	
Preferred name:		Social secu	Social security no:			
Mailing address:		City, State,	City, State, Zip			
Marital status:	Occupation:	Employer:		Work phone:		
Email address:		Cell phone:	Cell phone:		Home phone:	
May our office contact y	ou via text and email ab	out your appointr	nents? YES	NO (please	circle)	
BILLING INFORMA	TION					
Are you covered by <u>dental</u> insurance?		Do you have	Do you have Care Credit?			
=	work with Delta Dental. Vork. Any amounts not paid			-		
Primary dental insurance company:		Subscriber	name:	Subscriber SSN or ID#:		
Subscriber date of birth:	Group no:	Patient's relationship to subscriber:				
Secondary dental insurance company:		Subscriber	name:	Subscriber SSN or ID#:		
Subscriber date of birth:	Group no:	Patient's rel	Patient's relationship to subscriber:			
received and reviewed a copy of ask the denta	rue to the best of my knowled f the dental practice's privacy, so I practice's administrative staf	ecurity and breach not	ification policies and ons about these polic	procedures. I understa		
Patient Signature:			Date:			

Medical and Dental History

Patient Name:

Date of Birth:

DENTAL HISTORY

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

	Yes	No
Are you apprehensive about dental treatment?		
Have you had problems with dental treatments in the past?		
Do you gag easily?		
Do you wear dentures?		
Does food catch between your teeth?		
Do you have difficulty chewing food?		
Have you ever been told you have gum disease?		
Do you gums bleed easily?		
Do your gums bleed when you floss?		
Do your gums feel tender or swollen?		
Do you avoid brushing because of pain?		
Do you chew only on one side of your mouth because of pain?		
Do you ever notice slow-healing sores in or about your mouth?		
Are your teeth sensitive?		
Do you feel twinges of pain when your teeth com with:	e in cont	act
Hot foods or liquids?		
Cold foods or liquids?		
Sours?		
Sweets?		
Are you a habitual gum chewer or pipe smoker?		
Do you take fluoride supplements?		

	Yes	No
Are you dissatisfied with the appearance of your teeth?		
Do you prefer to save your teeth?		
Do you want complete dental care?		
How often do you brush?		
How often do you floss?		
Does your jaw make noise that bothers you or others?		
Do you clench or grind your jaws frequently?		
Do you jaws ever feel tired?		
Does your jaw get stuck so that you can't open freely?		
Does it hurt when you chew or open wide to take a bite?		
Do you have earaches or pain in front of the ears?		
Do you have any jaw symptoms or headaches upon waking in the morning?		
Do you take medications or pills for pain or discomfort?		
Do you have temporomandibular (jaw) disorder (TMJ)?		
Are you unable to open your mouth as far as you want?		
Do you have pain in the face, checks jaw, joints, throat or temples?		
Are you aware of an uncomfortable bite?		
Have you had a blow to the jaw (trauma)?		
Have you had Orthodontics (braces)		
If yes, when?		
Do you wear an occlusal night guard/splint?		

Medical and Dental History

Patient Name:

Date of Birth:

MEDICAL HISTORY

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

Yes

Chest pain

Shortness of breath

Blood pressure problem

Heart murmur

Heart valve problem

Taking heart medication

Rheumatic fever

Allergy Problems

Hay fever

Sinus problems

Skin rashes

Taking allergy medication

Asthma

Yes

No

Taking heart medication
Rheumatic fever
Pacemaker
Artificial heart valve
Pre-medication required by a physican

Intestinal Problems

Ulcers

Weight gain or loss

Special diet

Kidney or bladder problems

Blood
Easily bruising
Taking blood thinners
Recent INR:

Abnormal bleeding
Blood disease (anemia)
Required a blood transfusion

Bone or Joint Problems

Arthritis

Back or neck pain

Joint replacement (e.g. total hip, pins or implants)

Pre-medications required by physician

Osteoporosis

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

	Yes	No
Fainting spells, seizures or epilepsy		
Stroke / heart attack		
Frequent or severe headaches		
Thyroid problems		
Are you pregnant?		
Persistent cough or swollen glands		
Chemo therapy		
Tuberculosis or other respiratory disease		
Radiation therapy		
Type of cancer:		
Urinate more than 6 times a day		
Diabetes		
Most recent A1C:		
Family history of diabetes		
Thirsty or mouth is dry most of the time	_	
		-

	Yes	No
Do you drink alcohol?		
If so, how much?		
Do you use tobacco, marijuana or THC?		
If so, how much?		
Hepatitis, jaundice or liver trouble		
Herpes or other STD		
HIV-positive / AIDS		
Glaucoma		
Do you wear contact lenses?		
History of head injury		
History of alcohol or drug abuse		
Do you have any disease, condition or		
problem not listed above that you feel we		
should be aware of?		

Medical and Dental History

Patient Name:

Date of Birth:

ALLERGIES & MEDICATIONS

	Yes	No
Local anesthetics (Novocain)		
Penicillin or Amoxicillin		
Sulfa drugs		
Other antibiotics		
Barbiturates, sedatives (i.e. valium) or		
sleeping pills		
Aspirin, acetaminophen or ibuprofen		
Codeine, Demerol or other narcotics		
Hydrocodone		
Reaction to metals		
Latex or rubber dam		
List any other allergies or adverse reaction	ons to	
specific drug or materials:		
-		

Allergies

Antibiotics or sulfa drugs

List:

Anticoagulants / blood thinners
(Coumadin)

High blood pressure medication

Tranquilizers

Insulin, Orinase or similar drug

Aspirin

Digitalis or drugs for heart trouble

Nitroglycerin

Cortisone (steroids)

Osteoporosis medication (Fosamax,

Prolia, etc.)

Birth control

Hormone replacement

Are you taking any of the following?

Please list all medications and supplements			