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PINO
PERIODONTICS + IMPLANTS

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

Reason for Visit:	Referring Dentist:

*With your permission our office will share all relevant information about your treatment with your referring dentist(s). Please **initial here** to give permission: _____*

PATIENT INFORMATION

Patient name:	☐ Mr. ☐ Mrs. ☐ Dr. ☐ Ms. ☐ Miss.	Date of birth:	Gender:

Preferred name:	Social security no:
Mailing address:	City, State, Zip

Marital status:	Occupation:	Employer:	Work phone:
Email address:		Cell phone:	Home phone:

May our office contact you via text and email about your appointments? YES NO (please circle)

BILLING INFORMATION

Are you covered by dental insurance?	Do you have Care Credit?

The practice is in network with Delta Dental. We will bill to other dental insurance companies but we will be considered out of network. Any amounts not paid by your dental benefits within 60 days will be your responsibility.

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 relationship to subscriber:	

The above information is true to the best of my knowledge. I authorize my dental benefits be paid directly to the doctor. I have received and reviewed a copy of the dental practice's privacy, security and breach notification policies and procedures. I understand that I should ask the dental practice's administrative staff if I have any questions about these policies and procedures.

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 come in contact with:		
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:

Heart Problems	Yes	No
Chest pain	☐	☐
Shortness of breath	☐	☐
Blood pressure problem	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Pre-medication required by a physican	☐	☐

Allergy Problems	Yes	No
Hay fever	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Taking allergy medication	☐	☐
Asthma	☐	☐

Blood	Yes	No
Easily bruising	☐	☐
Taking blood thinners	☐	☐
Recent INR:		
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Required a blood transfusion	☐	☐

Intestinal Problems	Yes	No
Ulcers	☐	☐
Weight gain or loss	☐	☐
Special diet	☐	☐
Kidney or bladder problems	☐	☐

Bone or Joint Problems	Yes	No
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

Allergies

	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 reactions to specific drug or materials:

Are you taking any of the following?

	Yes	No
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	☐	☐

Please list all medications and supplements