W. Robert Pinner Jr., DMD, PA
500 B Red Banks Road
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**Patient Information Sheet**

Name: _____ Birthdate: _____
Address: _____ City: _____ State: ____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone : _____
Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Partnership ☐ Widowed
Employer: _____ Phone: _____
Address: _____ City: _____ State: ____ Zip: _____
Spouse, Partner, or Parent Name: _____
Emergency Contact: _____ Phone: _____
Whom may we thank for referring you to us? _____
How would you like us to confirm your appointments? ☐ Text – preferred number: _____
☐ Email – preferred email: _____

ALL SERVICES ARE RENDERED ON A CASH BASIS UNLESS OTHER ARRANGEMENTS ARE MADE WITH THE RECEPTIONIST BEFORE TREATMENT BEGINS.

How will the account be paid? ☐ Cash ☐ Check ☐ Debit/Credit Card
Who is responsible for this account? _____
Do you have a dental insurance plan? ☐ Yes ☐ No

Insurance Company: _____ Phone: _____
Subscriber's Social Security #: _____ Group #: _____ ID #: _____
Address: _____ City: _____ State: _____ Zip: _____
Employer offering this insurance? _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

**Dental History**

Reason for today's visit: _____
Date of last dental visit: _____ Date of last dental X-Rays: _____
Name of last/former dentist: _____ Phone: _____
Check if you have any problem with the following:

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Clicking or popping in jaw
- ☐ Food collection between certain teeth
- ☐ Grinding teeth
- ☐ Injury to Face / Jaws
- ☐ Loose or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to hot, cold, or sweets
- ☐ Sinus trouble
- ☐ Snoring / Sleep Apnea
- ☐ Sore throat
- ☐ Sores or growth in your mouth
- ☐ Trouble with Past Dental Treatment

How often do you brush: _____ How often do you floss: _____

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**Medical History**

Physician Name: _____ Date of last visit: _____

Have you ever had surgery?

Date(s) Surgery/Description

_____ _____

Have you ever been to the Emergency Room?

Date(s) Description / Reason for Visit

_____ _____

Women: Are You Pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Are you taking birth control? ☐ Yes ☐ No (please list below in medications)

Check if you have or have had any of the following:

- ☐ Anemia
- ☐ Anxiety / Depression
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valve(s)
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Chills
- ☐ Circulatory Problems
- ☐ Congenital Heart Problems
- ☐ Congestive Heart Failure (CHF)
- ☐ Cough (dry or productive)
- ☐ COPD
- ☐ Diabetes
- ☐ Easy Bleeding / Bruising
- ☐ Fainting / Dizziness
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Transplant
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hight Blood Pressure
- ☐ HIV / AIDS
- ☐ Jaw Pain
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Rash
- ☐ Recent Weight Gain / Loss
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizure / Epilepsy
- ☐ STD
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tobacco Use
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Other: _____

Please list all medications you are currently taking:

| **Medications:** | **(continued):** |
|---|---|
| | |
| | |
| | |
| | |
| | |

Please list any allergies you have (drug or other):

| **Allergy to:** | **What happens?** | **Last time it happened?** |
|---|---|---|
| | | |
| | | |
| | | |

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child/dependent has a change in health.

_____ _____

**Patient or Guardian Signature** **Date**