

Welcome to our Practice

Chart #.
FOR OFFICE USE ONLY

Patient Name:
Last First MI Preferred Name

Title: Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: SS #: Prev. Visit:

Email Address: Best time to call:

Phone:
Home Work Ext Mobile Fax Other

Address:

City State Zip Code

Whom may we thank for referring you to our practice?

In an emergency who should be notified? Please enter Name and Phone number below:

Peace Dental, P.C.
1509 Mount Royal Blvd.
Glenshaw PA 15116-2207

(412)486-5155
admin@peacedental.com
peacedental.com

Employer Information

The following is for: the patient the person responsible for payment

Employer Name: Phone:

Address:

City State Zip Code

Responsible Party Information:

This only need to be filled out if the insurance subscriber is other than the patient, or if the patient is under 18.

The following is for: the patient's spouse the person responsible for payment neither-not applicable

Name:
Last First MI Preferred Name

Title: Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: SS #: Driver's License #:

Email Address: Best time to call:

Phone:
Home Work Ext Mobile Fax Other

Address:

City State Zip Code

Primary Dental Insurance:

Name of Insured:
Last First MI

Insured's Birth Date: ID #: Group #:

Insured's Address:

City State Zip Code

Insured's Employer Name:

Employer Address:

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name:

Insurance Address:

City State Zip Code

Insurance Company Phone Number:

Insurance Authorization

- By checking this box,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Secondary Dental Insurance

Name of Insured:
Last First MI

Insured's Birth Date: ID #: Group #:

Insured's Address:

City State Zip Code

Insured's Employer Name:

Employer Address:

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name:

Insurance Address:

City State Zip Code

Insurance Company Phone Number:

Insurance Authorization:

- By checking this box,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Medical History

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- | | | |
|--|--|---|
| <input type="checkbox"/> *Pre-Med | <input type="checkbox"/> Allergies/Hay Fever | <input type="checkbox"/> Allergy Codeine |
| <input type="checkbox"/> ALLERGY LATEX | <input type="checkbox"/> Allergy Penicillin | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bisphosphonate | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Blood Thinners |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Growths | <input type="checkbox"/> H/L Blood Pressure |
| <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HIV | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> No EPI |
| <input type="checkbox"/> Other | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Venereal Disease | | |

- | | |
|---|--|
| <input type="checkbox"/> Ever been hospitalized (illness or injury) | <input type="checkbox"/> Presently being treated for any other illnesses |
| <input type="checkbox"/> Taking medication for weight control (ie fen-phen) | <input type="checkbox"/> Taking dietary supplements |
| <input type="checkbox"/> Subject to frequent headaches | <input type="checkbox"/> A smoker or smoked previously |
| <input type="checkbox"/> FEMALE: Taking birth control pills | <input type="checkbox"/> FEMALE: Pregnant |

Peace Dental, P.C.
1509 Mount Royal Blvd.
Glenshaw PA 15116-2207

(412)486-5155
admin@peacedental.com
peacedental.com

If any conditions or alerts selected above or not listed that needs further clarification, please describe below:

Do you take antibiotic premedication for your dental visits? If yes, please explain.

What is your estimate of your general health?

Excellent Good Fair Poor

Name of your physician and your most recent physical exam:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect you dental treatment.

List all medications, drugs, pills or herbal remedies, including regular dosages of aspirin.

Name and phone number of preferred pharmacy:

* By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and had responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

Dental Information

How would you rate the condition of your mouth?

- Excellent Good Fair Poor

Previous Dentist name and how long have you been a patient there:

Date of most recent dental exam:

Date of most recent dental x-rays:

I routinely see my dentist every:

- 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

What is your immediate concern?

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most)

Personal History, Check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Had an unfavorable dental experience | <input type="checkbox"/> Had complications from past dental treatment |
| <input type="checkbox"/> Had trouble getting numb | <input type="checkbox"/> Had any reactions to local anesthetic |
| <input type="checkbox"/> Had/have braces, orthodontic treatment | <input type="checkbox"/> Had your bite adjusted |
| <input type="checkbox"/> Had any teeth removed | |

Smile Characteristics, Check all that apply:

- Is there anything about the appearance of your teeth that you would like to change?
- Have you ever whitened (bleached) your teeth?
- Have you felt uncomfortable or self conscious about the appearance of your teeth?
- Have you been disappointed with the appearance of previous dental work?

Bite and Jaw Joint, Check all that apply:

- You have problems with your jaw joint
- You have problems chewing
- Your teeth changed in the last 5 years, become shorter, thinner, or worn
- Your teeth are crowding or developing spaces
- You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits
- You clench your teeth in the daytime or make them sore
- You have problems with sleep or wake up with an awareness of your teeth
- You wear or have worn a bite appliance

Tooth structure, Check all that apply:

- Cavities within past 3 years
- The amount of saliva in your mouth seems too little or you have difficulty swallowing any food
- You notice or have holes (i.e. pitting, crates) on the biting surface of your teeth
- Any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth
- Grooves or notches on your teeth, chipped teeth, or had a toothache or cracked filling
- Food gets caught between any teeth

Gum and Bone, Check all that apply:

- Gums bleed when brushing or flossing
- Treated for gum disease or were told you have lost bone around your teeth
- Noticed an unpleasant taste or odor in your mouth
- History of periodontal disease in your family

Peace Dental, P.C.
1509 Mount Royal Blvd.
Glenshaw PA 15116-2207

(412)486-5155
admin@peacedental.com
peacedental.com

- Experienced gum recession
- Had any teeth become loose on their own (without injury), or have difficulty eating an apple
- Experienced a burning sensation in your mouth

If any of the checked boxes need further explanation, please describe:

Name of patient, parent, or guardian completing this form:

*

Relationship to patient:

*

Response Date: