Peace Dental, P.C.
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(412)486-5155

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 Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
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:

_____

_____

Patient Occupation:

_____

_____

Employer Information

The following is for: ○ the patient ○ the person responsible for payment ○ both ○ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
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 ○ both ○ 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#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Primary Dental Insurance:

Name of Insured: _____ _____ ___
Last First MI

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

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insurance Company Phone Number:

Insurance Authorization

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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: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insurance Company Phone Number:

Insurance Authorization:

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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.

- ☐ *Pre-Med
- ☐ Allergies/Hay Fever
- ☐ Allergy Codeine
- ☐ ALLERGY LATEX
- ☐ Allergy Penicillin
- ☐ Allergy to Meds
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Autism
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Cancer
- ☐ Clindamycin Allergy
- ☐ Crohn's Disease
- ☐ Diabetic
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ H/L Blood Pressure
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ No EPI
- ☐ Osteoporosis Meds
- ☐ Other
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

- ☐ Ever been hospitalized (illness or injury)
- ☐ Presently being treated for any other illnesses
- ☐ Taking medication for weight control (ie fen-phen)
- ☐ Taking dietary supplements
- ☐ Subject to frequent headaches
- ☐ A smoker
- ☐ FEMALE: Taking birth control pills
- ☐ FEMALE: Pregnant

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:

☐ Had an unfavorable dental experience

☐ Had trouble getting numb

☐ Had/have braces, orthodontic treatment

☐ Had any teeth removed

☐ Had complications from past dental treatment

☐ Had any reactions to local anesthetic

☐ Had your bite adjusted

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

☐ 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:
____/____/_____