ADVANCED DENTAL SOLUTIONS
OF PITTSBURGH
DIGITAL DENTISTRY | COMPASSIONATE CARE

WELCOME!

Please complete the following Patient Information and Medical History Form in full and bring it with you to your first appointment. We look forward to meeting you!

ABOUT YOU:

NAME: _____

HOME ADDRESS: _____

_____

HOME PHONE: _____

WORK PHONE: _____

CELL PHONE: _____

E-MAIL ADDRESS: _____

SS#: _____-_____-_____

DOB: _____/_____/_____

MARITAL STATUS: _____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

_____

OCCUPATION: _____

SPOUSE INFORMATION:

SPOUSE'S NAME: _____

SPOUSE'S EMPLOYER: _____

SPOUSE'S SS#: _____

SPOUSE'S DOB: _____

DENTAL INSURANCE INFORMATION:

SUBSCRIBER NAME: _____

RELATION TO PATIENT: _____

SUBSCRIBER SS#: _____

SUBSCRIBER DOB: _____

INSURED EMPLOYER NAME: _____

INSURANCE COMPANY NAME AND ADDRESS:

_____

GROUP #: _____

Member ID #: _____

WHERE DID YOU HEAR ABOUT US?
(CHECK AS MANY AS APPLY)

☐ Insurance Provider List ☐ Phone Book

☐ IN Community Magazine ☐ Television

☐ Internet Search

☐ Patient Referral: (name) _____

☐ Other: _____

TODAYS DATE: _____

SIGNATURE: _____

Patient Medical History

Physicians Name:	Physicians Phone:
Pharmacy Name:	Pharmacy Phone:
Emergency Contact:	Emergency Contact Phone:

Have you ever been hospitalized or had a major operation? ☐ YES ☐NO _____

Have you ever had a serious head or neck injury? ☐ YES ☐NO _____

Do you have any artificial joints, valves, or implants? ☐ YES ☐NO _____

Patients with artificial joints, valves, or implants/prosthetics may require antibiotic pre-medication prior to dental treatment (including cleanings).

Do you require pre-medication for dental work? ☐ YES ☐NO _____

Please list any current medications and dosage/instructions:

_____

_____

Are you allergic to any of the following?

Aspirin	☐ YES	☐NO	Metals	☐ YES	☐NO
Codeine	☐ YES	☐NO	Penicillin	☐ YES	☐NO
Dental Anesthetics	☐ YES	☐NO	Tetracycline	☐ YES	☐NO
Erythromycin	☐ YES	☐NO	***Other:***		
Jewelry	☐ YES	☐NO			
Latex	☐ YES	☐NO			

Do you have any of the following medical conditions?

	Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	☐	☐	Diabetes	☐	☐	Low Blood Pressure	☐	☐
Abnormal Bleeding	☐	☐	Drug Addiction	☐	☐	Mitral Valve Prolapse	☐	☐
Alcohol Abuse	☐	☐	Emphysema	☐	☐	Pregnancy or Nursing	☐	☐
Alzheimer's disease	☐	☐	Epilepsy or Seizures	☐	☐	Psychiatric Care	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Radiation Treatments	☐	☐
Angina	☐	☐	Hay fever	☐	☐	Rheumatic Fever	☐	☐
Arthritis/Gout	☐	☐	Heart Attack/Failure	☐	☐	Shingles	☐	☐
Artificial Heart Valve	☐	☐	Heart Murmur	☐	☐	Sickle Cell Disease	☐	☐
Artificial Joint	☐	☐	Heart Pace Maker	☐	☐	Sinus Trouble	☐	☐
Asthma	☐	☐	Heart Trouble/Disease	☐	☐	Stroke	☐	☐
Blood Transfusion	☐	☐	Hemophilia	☐	☐	Thyroid Disease	☐	☐
Breathing Problem	☐	☐	Hepatitis A	☐	☐	Tonsillitis	☐	☐
Cancer	☐	☐	Hepatitis B or C	☐	☐	Tuberculosis	☐	☐
Cancer-Chemotherapy	☐	☐	High Blood Pressure	☐	☐	Ulcers	☐	☐
Cold Sores/Fever Blisters	☐	☐	Hives or Rash	☐	☐	Venereal Disease	☐	☐
Congenital Heart Disorder	☐	☐	Irregular Heartbeat	☐	☐	Yellow Jaundice	☐	☐

Do you use Tobacco? ☐ YES ☐NO If yes, what kind and how much? _____

TODAYS DATE: _____ SIGNATURE: _____