ADVANCED DENTAL SOLUTIONS OF PITTSBURGH
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WELCOME!

The benefits of a Happy, Healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please complete the following information in full so that we can better care for you. Be sure to complete the medical history information on the backside of this questionnaire.

ABOUT YOU:

NAME: _____

HOME ADDRESS: _____

_____

HOME PHONE: _____

WORK PHONE: _____

CELL PHONE: _____

E-MAIL ADDRESS: _____

SS#: _____ - _____ - _____

DOB: _____ / _____ / _____ AGE _____

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 ID OR SS#: _____

SUBSCRIBER DOB: _____

INSURED EMPLOYER NAME: _____

INSURANCE COMPANY NAME AND ADDRESS: _____

_____

GROUP #: _____

DO YOU HAVE SECONDARY INSURANCE COVERAGE?
☐ YES ☐NO

DENTAL HISTORY:

Why have you come to the dentist today? _____

_____

Do you require antibiotics before dental treatment?
☐ YES ☐NO

Have you experienced problems associated with any previous dental work? ☐ YES ☐NO

How would you describe your current dental health?
GOOD ☐ FAIR☐ POOR☐

Do you brush daily? ☐ YES ☐NO

Do you floss daily? ☐ YES ☐NO

Do your gums bleed? ☐ YES ☐NO

Would you like fresher breath? ☐ YES ☐NO

Would you like whiter teeth? ☐ YES ☐NO

Are you happy with the way your smile looks? ☐ YES ☐NO

Do you now or have you ever experienced discomfort in your jaw joint? ☐ YES ☐NO

What did you like most about your previous dental visit?

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

☐ Insurance Provider List ☐ Phone Book

☐ IN Community Magazine ☐ Television

☐ Internet Search

☐ Patient Referral: patient name _____

☐ Other: _____

TODAYS DATE: _____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you currently under a physicians care? ☐ YES ☐NO ☐N/A _____

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

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

Physicians Name:	Physicians Phone:
Pharmacy Name:	Pharmacy Phone:

Please answer the following:

Do you smoke or use tobacco? ☐ YES ☐NO
Are you currently on medication? ☐ YES ☐NO
If yes, please list the medications you are taking: _____

If you are female:

Are you taking birth control Pills? ☐ YES ☐NO
Are you pregnant? ☐ YES ☐NO If yes, # of weeks ____
Are you nursing? ☐ YES ☐NO

Allergies			***Allergies***		
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			

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

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform and necessary dental services that I may need during diagnosis and treatment with my informed consent. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Patient Signature:_____ ***Date:***_____