ALL FAMILY DENTISTRY 3247 West Liberty Avenue • Pittsburgh, PA 15216 • Office Telephone: 412 /344-5288

NAME: Last	First	Middle	PHONE NUMBERS HOME:
ADDRESS: Street or P.O. Box #	City	State Zip Code	WORK:
AGE. BIRTH DATE: Mo./Day/Year	SOCIAL SECURITY NO.		CELL:
OCCUPATION EMPLOYER	( ) Married ( ) Unmarried	( ) Separated ( ) Divorced	( ) Widowed
PERSON RESPONSIBLE FOR ACCOUNT			E-MAIL

INSURANCE INFORMATION

INSURED PERSON'S FULL NAME

RELATIONSHIP TO PATIENT

SOCIAL SECURITY NUMBER

GROUP OR UNION NAME

INSURANCE COMPANY NAME

EMPLOYER'S NAME

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to the above named dentist of the group insurance benefits, otherwise payable to me.

SIGNATURE

GETTING TO KNOW YOU

1. Why did you select our office?

2. Whom may we thank for referring you?

3. Is another member of your immediate family or a relative a patient in our practice?

4. Person to contact for emergency: _____
   Phone: _____

5. When was your last dental visit? _____

6. Doctor's name:

7. Have you ever had any teeth removed? _____
   Have these teeth been replaced? _____

PAYMENT ALTERNATIVES

Please check appropriate box:

- ❑ 1. As a special service to you, we offer a cash courtesy if you pay for your entire treatment plan in full, in advance.
- ❑ 2. Cash and personal checks are accepted as your treatments are provided.
- ❑ 3. Mastercard, Visa and Discover.
- ❑ 4. For long term extended payments, we offer a healthcare financing program, which when you are accepted, will allow extended small monthly payments for the treatment received.
- ❑ 5. If you have dental insurance, we want you to receive the full benefit of it. Our office staff can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignment of your insurance payment, another service to you. This means that you are responsible for your deductible and the portion the insurance does not cover. Remember, however, that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.

FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

SIGNATURE OF RESPONSIBLE PARTY RELATIONSHIP DATE

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? ..... ❑ YES ❑ NO
   If yes, for what reason? _____
2. Please provide the name and telephone number of your physician. _____
3. Have you been a patient in the hospital during the past two years? ..... ❑ YES ❑ NO
   If yes, for what reason? _____
4. Have you taken any medicine or drugs during the past two years? ..... ❑ YES ❑ NO
5. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? ..... ❑ YES ❑ NO
   If yes, please list: _____
6. Have you ever had excessive bleeding requiring special treatment? ..... ❑ YES ❑ NO
7. Check any of the following which you have had or have at present:

❑ Heart Failure	❑ Shortness of Breath	❑ HIV Positive (AIDS)
❑ Heart Disease or Attack	❑ Emphysema	❑ Hepatitis
❑ Angina Pectoris (chest pain)	❑ Hepatitis B (Serum)	❑ High Blood Pressure
❑ Tuberculosis (TB)	❑ Liver Disease	❑ Heart Murmur
❑ Asthma	❑ Yellow Jaundice	❑ Bruise Easily
❑ Rheumatic Fever	❑ Hay Fever	❑ Blood Transfusion
❑ Congenital Heart Lesions	❑ Allergies or Hives	❑ Drug Addiction
❑ Scarlet Fever	❑ Diabetes	❑ Hemophilia
❑ Artificial Heart Valve	❑ Thyroid Disease	❑ Venereal Disease (Syphilis, Gonorrhea)
❑ Heart Pacemaker	❑ X-Ray or Cobalt Treatment	❑ Cold Sores or Fever Blisters
❑ Heart Surgery	❑ Chemotherapy (Cancer, Leukemia)	❑ Genital Herpes
❑ Artificial Joint	❑ Arthritis	❑ Epilepsy or Seizures
❑ Anemia	❑ Rheumatism	❑ Fainting or Dizzy Spells
❑ Stroke	❑ Cortisone Medication	❑ Nervousness
❑ Kidney Trouble	❑ Glaucoma	❑ Psychiatric Treatment
❑ Ulcers	❑ Pain in Jaw Joints	❑ Sickle Cell Disease

8. Do you have any disease, condition or problem not listed? If so, please list. ..... ❑ YES ❑ NO
9. List all medications you are taking at this time. _____
   _____
10. Do you use or have you ever used recreational drugs? ..... ❑ YES ❑ NO
11. Do you ever wake up from sleep short of breath? ..... ❑ YES ❑ NO
12. Are you on a special diet? ..... ❑ YES ❑ NO
13. Are you having dental problems at this time? ..... ❑ YES ❑ NO
14. Do your gums bleed at any time? ..... ❑ YES ❑ NO
15. Do you feel very nervous about having dental treatment? ..... ❑ YES ❑ NO
16. Have you ever had a bad experience in the dental office? ..... ❑ YES ❑ NO
17. How do you feel about getting and maintaining a healthy mouth? _____
    _____
18. How do you feel about the appearance of your teeth? _____
    _____
19. If you could change anything about your smile, what would you change? _____
    _____
20. Women: Are you pregnant? ❑ YES ❑ NO If yes, what month are you due? _____
    Are you taking birth control pills? ..... ❑ YES ❑ NO