

**OAKMONT DENTAL ASSOCIATES**  
**DONALD A. STONER, D.M.D.**  
**154 Allegheny River Blvd.**  
**Oakmont, PA 15139-1801**  
**(412) 828-7750**

*Visit our website*  
[www.oakmontdental.net](http://www.oakmontdental.net)

**PATIENT INFORMATION**

Patient Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ (Nickname) \_\_\_\_\_  
Address \_\_\_\_\_  
Social Security # \_\_\_\_\_ Sex \_\_\_\_\_ Date of birth \_\_\_\_\_ Home phone \_\_\_\_\_  
Which formal salutation do you prefer when receiving a letter? None \_\_\_ Mr. \_\_\_ Mrs. \_\_\_ Miss. \_\_\_ Dr. \_\_\_ Rev. \_\_\_ Other \_\_\_  
In conversation, which do you prefer we use? First name \_\_\_ Formal salutation \_\_\_ Nickname \_\_\_  
Parent's names (If patient is a minor) \_\_\_\_\_ Phone \_\_\_\_\_  
Name of person to contact in case of an emergency \_\_\_\_\_ Phone \_\_\_\_\_  
Name of person responsible for payment \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_  
Employer of person responsible for payment \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_  
How did you hear about our office? \_\_\_\_\_

**INSURANCE**

The following information is necessary if you have insurance to help cover the cost of treatment. We help all patients to receive the benefits to which they are entitled, however, each patient is fully responsible for the cost of their treatment.

Insurance Company Name	Group #	Address	Name of Policy Holder
Dental _____	_____	_____	_____
Dental _____	_____	_____	_____
Medical _____	_____	_____	_____
Other _____	_____	_____	_____

(Optional) I hear by authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me. Signed (Insured person) \_\_\_\_\_ Date \_\_\_\_\_

**DENTAL HISTORY**

Previous Dentist \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_  
Last Visit \_\_\_\_\_ May we contact previous dentist for records? \_\_\_\_\_  
Reason for changing dentists \_\_\_\_\_  
Reason for this appointment \_\_\_\_\_

YES NO Do you have, or have you ever had any of the following (Please describe):  
\_\_\_\_ \_\_\_\_ Periodontal (gum) disease \_\_\_\_\_  
\_\_\_\_ \_\_\_\_ Orthodontic treatment (braces) \_\_\_\_\_  
\_\_\_\_ \_\_\_\_ Oral herpes, cold sores, viral infections \_\_\_\_\_  
\_\_\_\_ \_\_\_\_ Trench mouth, ANUG, painful bacterial infections \_\_\_\_\_  
\_\_\_\_ \_\_\_\_ Dental procedures with complications \_\_\_\_\_  
\_\_\_\_ \_\_\_\_ Prolonged bleeding during dental treatment \_\_\_\_\_  
\_\_\_\_ \_\_\_\_ Pain in or near ears or TMJ \_\_\_\_\_  
\_\_\_\_ \_\_\_\_ Unhealed area, growth, or tumor in the mouth \_\_\_\_\_  
\_\_\_\_ \_\_\_\_ Bleeding Gums \_\_\_\_\_  
\_\_\_\_ \_\_\_\_ Frequent Headaches \_\_\_\_\_  
\_\_\_\_ \_\_\_\_ Clenching or grinding of teeth \_\_\_\_\_  
\_\_\_\_ \_\_\_\_ Apprehension or fear of dental treatment \_\_\_\_\_  
\_\_\_\_ \_\_\_\_ Are you satisfied with the appearance of your teeth and smile? If not, inform us about what you would like to change. Might you be a candidate for tooth whitening, tooth colored restorations or other esthetic treatment?

**MEDICAL HISTORY**

Physician(s) \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Last visit \_\_\_\_\_ Treatment received \_\_\_\_\_ May we contact your physician for information? \_\_\_\_\_

Current medical treatment \_\_\_\_\_

Current medications/drugs (including birth control pills)/ supplements etc. \_\_\_\_\_

YES	NO	Do you have, or have you ever had any of the following (Please describe):
___	___	Allergy to anything resulting in hives, rash, asthma, etc. _____
___	___	A reaction to any medication or drugs _____
___	___	A diet prescribed by a physician _____
___	___	A heart problem (mitral valve prolapse, murmur, etc.) _____
___	___	High blood pressure _____
___	___	Liver disease (hepatitis, jaundice, etc.) _____
___	___	Sexually transmitted disease ( HIV, AIDS, Herpes, Syphilis, Ghonorrhea, etc.) _____
___	___	Kidney or urinary disease _____
___	___	Persistent cough, night sweats _____
___	___	Lung disease (Asthma, Emphysema, TB, Pneumonia, etc.) _____
___	___	Rheumatic fever _____
___	___	Diabetes ( type I or type II ) _____
___	___	Tumor or growth _____
___	___	Malignancy _____
___	___	Stomach or intestinal disease (ulcer, colitis, etc.) _____
___	___	Rheumatism, or arthritis _____
___	___	Artificial prosthesis ( heart valve, joint, etc. ) _____
___	___	Organ transplant _____
___	___	Compromised immune system _____
___	___	Serious head injury _____
___	___	History of fainting _____
___	___	Smoke or use tobacco products _____
___	___	Pregnant _____

Any other information you feel may be helpful:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PATIENT SIGNATURE:**

**DATE:**