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

Visit our website
www.oakmontdental.net

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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, Syphillis, 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:

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PATIENT SIGNATURE: **DATE:**

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