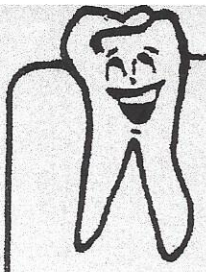

WEST PENN DENTAL CENTERS, INC.
312 Second Avenue
Carnegie, PA 15106
279-PENN (7366)

Patient Information

Welcome to our office. It is our sincere hope that your visits here will be comfortable and satisfying. Please take a few minutes to complete this confidential questionnaire so that we may render the best treatment for you.
* Our HIPA Policy on Display

Thank You

PATIENT'S NAME _____ BIRTHDATE _____ SEX: ☐ MALE ☐ FEMALE

PATIENT'S ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____

PATIENT'S EMPLOYER _____ EMPLOYER'S ADDRESS _____

WORK PHONE _____ NO. YEARS EMPLOYED _____ SOC. SEC. NO. _____ CELL # _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED EMAIL ADDRESS _____

SPOUSE'S NAME _____ NO. OF DEPENDENTS _____ SPOUSE'S SOC. SEC. NO. _____

SPOUSE'S EMPLOYER _____ SPOUSE'S EMPLOYER'S PHONE NO. _____

EMERGENCY TELE. NO. (OTHER THAN RESIDENCE) _____ RELATIONSHIP TO PATIENT _____

WHO WILL PAY THIS ACCOUNT? (WHOSE NAME WILL APPEAR ON BILLING STATEMENT) ☐ SELF ☐ SPOUSE ☐ PARENT OR GUARDIAN

WHO MAY WE THANK FOR REFERRING YOU TO US? _____

IF YOUR SPOUSE, PARENT OR GUARDIAN IS RESPONSIBLE FOR YOUR ACCOUNT, PLEASE FILL IN THIS SECTION.

RESPONSIBLE PARTY'S NAME _____ BIRTHDATE _____ SEX: ☐ MALE ☐ FEMALE

ADDRESS _____ PHONE _____

RESPONSIBLE PARTY'S EMPLOYER _____ NO YEARS. EMPLOYED _____ SOC. SEC. NO. _____

EMPLOYER'S ADDRESS _____ PHONE _____

DO YOU HAVE DENTAL INSURANCE COVERAGE? ☐ YES ☐ NO (IF "YES" PLEASE COMPLETE THE "INSURANCE INFORMATION" FORM)

FAMILY DOCTOR'S NAME _____ ADDRESS _____ PHONE _____ DATE OF LAST PHYSICAL EXAM _____

ARE YOU THE MEMBER OF A UNION GROUP? IF SO, WHICH ONE? _____ DO YOU HAVE MASTER CARD OR VISA? ☐ YES ☐ NO

IF YOU HAVE, OR HAVE HAD, ANY OF THE FOLLOWING, PLEASE WRITE "YES":

_____ANY HEART PROBLEMS	_____EXCESSIVE BLEEDING	_____MALIGNANCIES	_____STROKE	_____TUBERCULOSIS
_____HIGH BLOOD PRESSURE	_____ALLERGIES TO ANESTHETICS	_____MUMPS	_____ANEMIA	_____ULCER
_____LOW BLOOD PRESSURE	_____HEPATITIS (Date_____)	_____PSYCHIATRIC CARE	_____ARTHRITIS	_____VENERAL DISEASE
_____CIRCULATORY PROBLEMS	IS YOUR DISEASE STILL	_____RHEUMATIC FEVER	_____ASTHMA	_____AIDS
_____NERVOUS PROBLEMS	ACTIVE? _____	_____SCARLET FEVER	_____DIABETES	I AM ALLERGIC TO THE
_____RADIATION TREATMENTS	_____PREVIOUS SURGERY	_____SINUS PROBLEMS	_____EPILEPSY	FOLLOWING MEDICATIONS:
_____HEART MURMER	_____Joint Replacement/Artificial Limbs	_____CARDIAC PACEMAKER	_____TONSILITIS	_____
				_____

ARE YOU PREGNANT? _____ BLOOD PRESSURE: S_____ / D_____

ARE YOU HAVING ANY DISCOMFORT AT THIS TIME? _____

HOW LONG SINCE YOU HAVE BEEN TO A DENTIST? _____

WAS YOUR TREATMENT COMPLETED? _____

DID YOU HAVE X-RAYS? _____

HOW OFTEN DID YOU VISIT A DENTIST BEFORE THEN? _____

HAVE YOU LOST ANY TEETH? _____

WHY? _____

ANY COMPLICATIONS WITH EXTRACTIONS? _____

DENTURE / PARTIAL WEARERS:
HOW OLD IS YOUR APPLIANCE? _____

IS THERE FLUORIDE IN YOUR WATER? _____

I AM CURRENTLY TAKING THE FOLLOWING MEDICATIONS:

	MEDICATION	TIMES PER DAY
1.		
2.		
3.		
4.		

HOW CAN WE HELP YOU? _____

_____

_____

PLEASE REMEMBER PAYMENT IS EXPECTED WHEN SERVICES ARE PERFORMED. IF PROCEDURES ARE COVERED IN WHOLE OR IN PART BY DENTAL INSURANCE, I AUTHORIZE PAYMENT TO WEST PENN DENTAL CENTERS. ANY AND ALL BALANCES, DEDUCTIBLES AND UNCOVERED SERVICES, WILL BE MY RESPONSIBILITY.

_____ _____

SIGNATURE DATE