

Date _____

Print Name _____

Puredent, Inc.
Tammy DeGregorio DMD
www.puredent.net
(412) 631-8947

Welcome to Our Practice!

We are complimented that you have selected us to provide your dental care.

Whom may we thank for referring you to our office? _____

Guest Information

Completed guest information will allow us to ensure your safety in case of emergency, to process your insurance claims as a courtesy to you, to alert you to unexpected schedule openings, and to correspond regarding dental matters. Thank you!

Guest's Last Name _____ First Name _____

Middle _____ Title _____ Preferred Name _____ Marital Status _____

Social Security _____ - _____ - _____ Birth Date _____ / _____ / _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ - _____ - _____ Cell Phone _____ - _____ - _____

Pager _____ - _____ - _____ E-Mail _____

Occupation _____ Employer _____

Employment Address _____

Work Phone _____ - _____ - _____

Emergency Contact _____ Phone _____ - _____ - _____

Relationship to Guest _____ Phone _____ - _____ - _____

For Full-Time College/University Students: School _____

Phone at School _____ - _____ - _____

E-Mail at School _____

Responsible Party Information if Different From Above

Last Name _____ First Name _____

Middle _____ Relationship to Patient _____

Social Security _____ - _____ - _____ Birth Date _____ / _____ / _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ - _____ - _____

Occupation _____ Employer _____

Employment Address _____

Work Phone _____ - _____ - _____

Print Name _____

Medical Information

Have you been a patient in the hospital during the past two years? Yes No

Have you been under the care of a medical doctor during the past two years for a specific condition? Yes No

Date of most recent medical exam: _____

Physician's Name _____ Physician's Address _____

Physician's Phone _____ - _____ - _____

Please list any medication or drugs you are taking, including prescription medications, over the counter medications, herbal or holistic remedies, vitamins minerals, etc. _____

Please list any medication or anesthetics to which you are allergic. _____

Do you need to pre-medicate prior to dental treatment? Yes No

Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure	Yes	No	Sinus Trouble	Yes	No	Fainting or Dizzy Spells	Yes	No
Heart Disease or Attack	Yes	No	Hay Fever	Yes	No	Involvement in Accident	Yes	No
Angina Pectoris	Yes	No	Respiratory Problems	Yes	No	Whiplash Injury	Yes	No
Congenital Heart Disease	Yes	No	Allergies	Yes	No	Severe Blow to Head	Yes	No
Heart Murmur	Yes	No	Latex Allergy	Yes	No	Severe Blow to Jaw	Yes	No
High Blood Pressure	Yes	No	Codeine Allergy	Yes	No	Chronic Back Pain	Yes	No
Arteriosclerosis	Yes	No	Penicillin Allergy	Yes	No	Chronic Shoulder Pain	Yes	No
Mitral Valve Prolapse	Yes	No	Hepatitis A (infectious)	Yes	No	Chronic Neck Pain	Yes	No
Artificial Heart Valve	Yes	No	Hepatitis B (serum)	Yes	No	Stiff Neck Muscles	Yes	No
Heart Pacemaker	Yes	No	Hepatitis C	Yes	No	Tension Headaches	Yes	No
Heart Surgery	Yes	No	Venereal Disease	Yes	No	Migraine Headaches	Yes	No
Stroke	Yes	No	Cold Sores/Fever Blisters	Yes	No	Headaches Back of Head	Yes	No
Rheumatic Fever	Yes	No	Blood Transfusion	Yes	No	Headaches Temple Area	Yes	No
Anemia	Yes	No	Hemophilia	Yes	No	Chronic Facial Pain	Yes	No
Arthritis	Yes	No	Sickle Cell Disease	Yes	No	Pain in Jaw Joint	Yes	No
Rheumatism	Yes	No	Hives	Yes	No	Clicking, Popping Jaw	Yes	No
Cortisone Medication	Yes	No	Easy Bruising	Yes	No	Locking Jaw	Yes	No
Artificial Joints (hip, etc.)	Yes	No	Yellow Jaundice	Yes	No	Tired Jaw After Sleep	Yes	No
Liver Disease	Yes	No	Epilepsy or Seizures	Yes	No	Tired Jaw After Meal	Yes	No
Kidney Trouble	Yes	No	Nervousness	Yes	No	Foods You Avoid	Yes	No
Diabetes	Yes	No	Anorexia/Bulimia	Yes	No	Aching Jaw Opening Wide	Yes	No
Ulcers	Yes	No	Wisdom Tooth Extraction	Yes	No	Difficulty Opening Wide	Yes	No
Thyroid Problems	Yes	No	Bleeding Gums Brushing Teeth	Y	N	Trouble Sleeping	Yes	No
Glaucoma	Yes	No			Cracking In Jaw Joint	Yes	No
Cancer	Yes	No	Family History of Jaw Problems	Y	N	Teeth Clenching	Yes	No
Radiation Therapy	Yes	No	Ear Pain	Yes	No	Teeth Grinding at Night	Yes	No
Chemotherapy	Yes	No	Itchiness in Ear	Yes	No	Sore Teeth After Sleep	Yes	No
Emphysema	Yes	No	Stuffiness in Ear	Yes	No	Blurred Eyesight	Yes	No
Chronic Cough	Yes	No	Ringing/Buzzing in Ear	Yes	No	Snoring	Yes	No
Tuberculosis	Yes	No	Hissing/Grating in Ear	Yes	No	Chronic Stuffed Nose	Yes	No
Tumors	Yes	No	Loss of Hearing	Yes	No	Recurring Nausea	Yes	No
Asthma	Yes	No	Pain In/Around/Behind Ear	Yes	No			

Do you have or have you had any disease, condition or problem not listed on the previous page? Yes No

If yes, please identify _____

Did you take the diet drug Fen-Phen that is no longer on the market? (You may need to pre-medicate.) Yes No

Do you have any disease, are you taking any medication/drugs, or have you had any transplant operation that has or may have depressed your immune system? Yes No

Do you have a history of alcohol or chemical dependency or of an emotional disorder or of any developmental disability that may have an impact on your needs or on the care we provide you? Yes No

Do you wish to speak with the doctor privately about anything? Yes No

For Women: Are you pregnant? Yes No Due date _____
 Are you nursing? Yes No Are you taking birth control pills? * Yes No

* If you are using non-mechanical contraceptives, antibiotics *may* interfere with their effectiveness. Consult your physician; you may wish to use mechanical forms of birth control for one full cycle after completion of antibiotic treatment.

If you experience headaches, please complete the following questions.

If you take medication for pain relief, what do you take? _____ N/A

How often do you take it? _____ N/A

When are your symptoms the worse? _____ N/A

Does anything make you feel better? _____ N/A

If you have been involved in a serious accident, will you provide details? _____
 _____ N/A

When you experience headaches, do you also experience the following? _____ Fatigue
 _____ Nausea _____ Light Sensitivity _____ Noise Sensitivity _____ Blurred Vision _____ Dizziness

Please indicate the location and type of pain. Key: L = Left R = Right B = Both Sides

			Severity			Frequency			Duration				
Location			Mild	Moderate	Severe	Occasional	Frequent	Constant	Seconds	Minutes	Hours	Days	Weeks
L	R	B	Front of your head										
L	R	B	Entire head										
L	R	B	Back of your head										
L	R	B	In your temples										

Do you fear dental work? Yes No

Ideally, is there anything you wish to change about the appearance of your smile (discolored, crooked, crowded teeth or fillings, gaps, missing teeth, too small or too large teeth, gummy smile, etc.)?

Consent:

- 1. I understand that the above information is necessary for the doctors to provide me with comprehensive dental care in a safe manner. I have answered all questions truthfully and to the best of my knowledge.
- 2. I authorize the doctors of **Puredent Inc.** to take radiographs and photographs, make study models, or employ other diagnostic aids deemed appropriate by them for the purpose of making a thorough diagnosis of my dental needs.
- 3. I authorize the doctors of **Puredent Inc.** to perform all recommended treatment with which I have agreed and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk.
- 4. I authorize the release of examination findings, diagnosis, treatment program, etc., to my referring or treating dental specialists and/or physicians.
- 5. I understand that all responsibility for payment for dental services provided in this office for myself and/or for my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made.
- 6. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.
- 7. If I am 18 years of age or older and if my parents/guardians are my guarantors, I give permission for **Puredent Inc.** to place a phone call to my parents'/guardians' home regarding account balances, and/or account credits and/or to mail statements or other information to my parents'/guardians' home address regarding account balances, and/or account credits.

Guest Signature _____ Date _____

OR

Signature of Parent or Responsible Party _____

Relationship to Guest _____ Date _____

Provided that my name is not revealed, I authorize the doctors of **Puredent Inc.** to use study models, radiographs, photographs of my mouth, etc. in lectures or seminars which the doctors conduct, in articles or columns which the doctors author, or in before/after displays that the practice mounts.

Guest Signature _____ Date _____

Puredent Inc. is committed to the art of dentistry through leading-edge technology and personalized, comfortable care.