TODAY'S Dentistry

Dr. Matthew D. LaNeve, D.D.S
5012 Route 8 | Gibsonia, PA 15044 | 724-443-1300

Patient Information

Name_____Name you go by_____Social Security #_____

Address_____City_____State_____Zip Code_____

Home Phone_____Cell Phone_____E-Mail_____

Birthdate_____ Sex _____F _____ M

Patient Employed by_____Occupation_____

Business Address_____ Business Phone_____

Whom may we thank for referring you?_____

Dental History

How can we help you?_____

Last Dental Visit_____Reason for last visit_____

What things have you liked or not liked at other doctor offices_____

List any past procedures (i.e. whitening, crowns, filling, etc.)_____

Please tell us about any negative experiences or complications you have had in the past_____

Do you experience or would you like to discuss any of the following items? please check

___missing teeth	___difficulty with chewing	___headaches	___color of teeth
___bleeding gums	___sensitivities(even small ones)	___bad breath	___appearance of your teeth or smile
___crooked teeth	___areas where food gets caught	___old fillings	___keeping your teeth
___veneers	___drill-less dentistry	___bridges	___tooth colored fillings
___implants	___air abrasion (decay removal)	___porcelain crowns	___whitening your teeth
___bonding	___sealants	___inlays/onlays	___straightening teeth without braces

Health History

Current medication_____Reason for medication_____

Current medication_____Reason for medication_____

Current medication_____Reason for medication_____

If more than three medications, please list on back. Thank you.

Allergies_____

Past/Present Health Conditions (i.e. Heart, Diabetes, TB, High Blood Pressure, Surgeries, Etc)_____

_____

Person to contact in case of an emergency_____Phone_____

Authorization

I acknowledge notification and receipt of the Notice of Privacy Practice.
I give consent to use or disclose protected health information to another family member in order to carry out treatment, payment , and healthcare operations. (please list name(s)

Name _____ Relationship _____

_____ _____

I authorize use of my name to be printed in the newsletter either as "being welcomed as a new patient or being thanked for referring a patient".
I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered.
I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature (Parent or Guardian if under 18 years of age) _____Date_____