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

Whom may we thank for referring you?_____

Patient Employed by_____Occupation_____

Business Address_____ Business Phone_____

Family physician(s)_____Last physical_____

Physician's Address/Phone Number _____

In case of emergency, Contact person _____Phone Number_____

Authorization

Privacy Act
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**_____

FOR OFFICE USE ONLY

Health Update

Has there been any change in your general health in the past year? (allergies, new medications, vitamins)

YES NO Date_____ Describe:_____
YES NO Date_____ Describe:_____
YES NO Date_____ Describe:_____
YES NO Date_____ Describe:_____
YES NO Date_____ Describe:_____

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Health Questionnaire

Name:_____Date:_____

Present Health Status: (Circle one) EXCELLENT GOOD FAIR POOR DON'T KNOW

YES NO Have you had a serious illness, operation or hospitalization during the past five years? If yes, please describe:
_____

YES NO Are you taking or have you recently taken any prescribed medication or inhalers? (please list medication & reason)
_____

YES NO Over the counter medication, natural or herbal preparations?_____

YES NO Have you ever taken Pondimin (Fendluramine), Phen-Fen (Phentermine) or Redux (Dexphenfluramine) for weight loss?
_____

YES NO Has your physician told you to take antibiotics prior to having any type of dental procedure? If so, why?
_____What do you take?_____

YES NO Are allergic to any medication, drugs, latex or iodine?_____

YES NO Have you ever had an adverse reaction to any drugs, anesthetics, sedatives, narcotics, aspirin, ibuprofen (Motrin)
_____

YES NO Have you ever had excessive bleeding that required special treatment?_____

YES NO Have you been diagnosed as having immunodeficiency, systemic Lupus, or Aids?_____

YES NO Is there a history of Diabetes in your family?_____

YES NO Are you required, due to health, to restrict your work or activity in any way?_____

YES NO Are you on a special or restricted diet of any kind?_____

YES NO Do you use any kind of tobacco? If so, how much:_____per day, week, month How long?_____

YES NO Do you have any history of substance abuse or do you currently use recreational drugs?
_____

What types of beverages do you drink throughout the day?_____

Check the following that applies to you:

___chest pain upon exertion
___shortness of breath
___high blood pressure
___low blood pressure
___heart valve prosthesis
___mitral valve prolapse
___congenital heart lesion
___rheumatic fever
___heart murmur
___damaged heart valve
___heart arrhythmia
___tachycardia
___heart surgery
___cardiac pacemaker
___cerebral vascular disease

___hepatitis or jaundice
___elevated cholesterol
___neurological disorders
___stroke
___headaches
___received blood transfusion
___impaired liver function
___kidney disease
___impaired kidney function
___esophygeal reflux
___hiatal hernia
___G.I. Ulcers
___anorexia or bulimia
___irritable bowel syndrome

___colitis
___diabetes
___Crohn's disease
___radiation therapy
___chemotherapy
___history of cancer
___migraines
___epilepsy
___seizures
___mental health problems
___joint replacement surgery
___arthritis
___connective tissue disorder

___sleep apnea
___asthma
___bronchitis
___emphysema
___sinus problems
___persistent cough
___tuberculosis
___glaucoma
___contact lenses
___severely impaired vision
___cold sores, fever blisters

Do you have any disease, problem or condition that is not listed above? If so, please explain:

_____

For women, check all that apply: _____I am pregnant _____I am nursing _____I am taking birth control pills

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Specific Dental Concerns and Experiences

Name:_____Date:_____

1. Are you presently satisfied with the condition of your mouth and teeth? (circle one)

1 2 3 4 5 6 7 8 9 10

2. What level of dental health do you aspire to? (circle one)

EXCELLENT GOOD FAIR NOT IMPORTANT

3. How would you rate your smile at this time? (circle one)

1 2 3 4 5 6 7 8 9 10

4. Are there times in social situations where you are embarrassed by your smile/teeth?

1 2 3 4 5 6 7 8 9 10

5. Are there some things you would like to change about your teeth/smile? _____

_____

6. Any dental fears or significant past dental experience? _____

7. Do you tolerate most dental care reasonably well?_____

8. What are some things you have liked about your previous dentist or dental office? _____

_____

9. What are some things you haven't liked about previous dentists or dental offices?_____

_____

YES NO Would you like to discuss any of the following? (please check)

_____missing teeth
_____implants
_____veneers
_____old silver fillings
_____tooth colored fillings
_____drill-less dentistry
_____air abrasion (decay removal)
_____porcelain crowns
_____whitening your teeth
_____straightening teeth without braces