David A. Huber, D.M.D., PC

213 East Main Street
Evans City, PA 16033
724-538-848

Admission Information Sheet:

Patient Name:_____
Address:_____**City:**_____**State:**_____**Zipcode:**_____
Phone:_____**Cell Phone:**_____**E-Mail:**_____
Date of Birth_____
Medical Physician:_____
Present Medication: (Please use back if necessary):_____
Medication Allergies:_____
Allergies:_____
Are you sensitive to Metals or Latex?_____

Please circle the appropriate answer, and comment as necessary:

Could you be pregnant?	Yes ☐ No ☐
Do you have Heart Disease?	Yes ☐ No ☐
Are you aware of a Heart Murmur?	Yes ☐ No ☐
Do you have high or low blood pressure?	Yes ☐ No ☐
Do you have inflammatory or auto immune disease?	Yes ☐ No ☐
Do you have blood disorders, anemia, leukemia?	Yes ☐ No ☐
Do you have kidney problems?	Yes ☐ No ☐
Are you a diabetic?	Yes ☐ No ☐
Do you have respiratory problems, bronchitis, Emphysema or COPD?	Yes ☐ No ☐
Do you have epilepsy, or seizure disorders?	Yes ☐ No ☐
Do you have or have had TB or hepatitis?	Yes ☐ No ☐
Are you HIV positive?	Yes ☐ No ☐
Do you have AIDS?	Yes ☐ No ☐
Do you have artificial joints/prosthesis/heart valves?	Yes ☐ No ☐
Do you bleed excessively?	Yes ☐ No ☐
Do you smoke, chew, or use snuff?	Yes ☐ No ☐
Do you consume alcohol?	Yes ☐ No ☐
Have you been treated with chemotherapy or radiation?	Yes ☐ No ☐
Have you had a serious illness, operation, or have been hospitalized in the past 5 years?	Yes ☐ No ☐

If you marked yes, what was the illness or problem?

Please turn this form over and complete the back portion:

Dental History:

Do your gums bleed when you brush or floss?	Yes ☐ No ☐
Are your teeth sensitive to cold, hot, sweets, or pressure?	Yes ☐ No ☐
Does food or floss catch between your teeth?	Yes ☐ No ☐
Have you had any periodontal treatments?	Yes ☐ No ☐
Have you had any orthodontic treatments?	Yes ☐ No ☐
Is your home water supply fluoridated?	Yes ☐ No ☐
Are you currently experiencing dental discomfort or pain?	Yes ☐ No ☐
Do you have earaches or neck pain?	Yes ☐ No ☐
Do you have clicking, popping or discomfort in the jaw?	Yes ☐ No ☐
Do you brux or grind your teeth?	Yes ☐ No ☐
Do you have ulcers or sores in your mouth?	Yes ☐ No ☐
Do you wear dentures or partials?	Yes ☐ No ☐
Do you participate in active recreational activities?	Yes ☐ No ☐
Have you ever had a serious injury to your head or mouth?	Yes ☐ No ☐

Date of last dental exam:_____

Date of last X-ray:_____

Release:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits.

I authorize release of any information concerning my health care, advice and treatment to another dentist.

I understand that my dental care insurance carrier may pay less than the actual bill for services. I understand I am financially responsible for payment in full of all accounts not paid In whole or in part by my dental insurance carrier.

I attest to the accuracy of the information on this page.

I have received a copy of the Notice of Privacy Practices

Patients /Guardian's
Signature_____Date_____

Rev: 11/2008

PRINT