David A. Huber, D.M.D., PC
8890 Peebles Road
Allison Park, PA 15101

Patient Name:____ Date of Birth:_______________
Address:____
City:________________________________ State:_____________ Zip:_______________
Home Phone:____________________ Cell Phone:_____________________ Allow Texting: Yes or No
Email:_______________________________________ Social Security #:__________________________
Emergency Contact:_____________________________________ Phone:________________________

Present Medications (use back if needed):____
Allergies:_______________________________ Medication Allergies:________________________________
Pharmacy:__________________________________ Location:____________________________________
Sensitivity to any metals or latex? ____
Any major health problems?____
Have you had any serious illness, operations or have been hospitalized in the past 5 years? Y or N
If yes, what was the concern?____

Respiratory problems or bronchitis?	Y or N	Treated with chemotherapy or radiation?	Y or N
Emphysema or COPD?	Y or N	Do you have heart disease?	Y or N
Any chance of pregnancy?	Y or N	Are you diabetic?	Y or N
High or low blood pressure?	Y or N	Do you have HIV or AIDS?	Y or N
Any inflammatory or autoimmune disease?	Y or N	Any excessive bleeding?	Y or N
Epilepsy or seizure disorders?	Y or N	Do you have TB or Hepatitis?	Y or N
Any artificial joints/prosthesis/heart valves?	Y or N	Do you consume alcohol?	Y or N
Are you required to take pre-med antibiotics?	Y or N	Do you smoke/vape/chew/use snuff?	Y or N

Date and practice of last dental exam (if elsewhere):________________________ Date of last xray:_________
Have you had any periodontal treatment? Y or N Treating Doctor:__________________________
Any serious injuries to the head or mouth? Y or N Please explain: __________________________
Any tooth sensitivity to hot/cold, sweet or pressure? Y or N
Any current dental pain or discomfort? Y or N Please describe:__________________________

Dental Insurance Company:____________________________________ Member ID#____________________
Are you married or single? __________________________ Are you the Subscriber/Policy Holder? Y or N
If not, who is the Subscriber?________________________________ Subscriber Date of Birth: ______________
Relationship to Subscriber? _______________________

Release:
I authorize the dentist to perform diagnostic and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my healthcare, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I authorize the release of any information concerning my healthcare, advice or treatment to another dentist. I understand that my dental insurance carrier may pay less than the actual bill for service. I understand that I am financially responsible for payment in full of all accounts not paid in full or in part by my dental insurance carrier. I attest to the accuracy of the information provided on this page. I have reviewed the posted copy of the Notice of Privacy Practices & Written Financial Policy.

Patient or Guardian's Signature:____ **Date**:________________