TO: Mark J. Weingarden, D.M.D.
Castle Town Square North
4290 Route 8, Suite 104
Allison Park, PA 15101
(412) 487-8288 • Fax: (412) 486-4668

FROM: ______________________________

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PATIENT REFERRED______________________________ DATE______________________________

PERTINENT MEDICAL HISTORY:

(Please circle): Heart Murmer MVP RhF STD Hepatitis TB AIDS

Drug Allergies: PCN ASA LA Other:

Premedication: Yes No

PERTINENT DENTAL HISTORY:

( ) Recent periodontal treatment completed or initiated______________________________

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( ) No recent periodontal treatment.

( ) Other:______________________________

DENTIST CONCERNS:

A. Periodontal Disease (sites) ____________

B. Crown Elongation (tooth #) ____________

C. Grafting (tooth #) ____________

D. Implants (sites) ____________

E. TMJ Evaluation ____________

F. Occlusal Evaluation ____________

G. Patient Motivation ____________

H. Other ____________

Note: ______________________________

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PATIENT CONCERNS:

A. Fear ____________

B. Fees ____________

C. Insurance ____________

D. Cosmetics ____________

E. Scheduling Difficulties ____________

F. Dental Awareness: Low Med High

G. Other ____________

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Note:______________________________

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RESTORATIVE TREATMENT PLANS: (Please include dentistry you would like reinforced)

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X-RAYS AVAILABLE / DATE:

Bite Wings ____________

FMX ____________

PAN ____________

SHOULD WE CALL THIS PATIENT? YES NO

Phone______________________________

Phone______________________________