Patient Acquaintance Form

Name:______________________________Address:____________________________________

City:______________________State:_____Zip:__________Home Phone:_________________

Work Phone:_______________________ Cell:______________________________________

Birthdate: ____/_____/_____ Sex: (M /F) Social Security #:____-_____-______ Marital Status: ___

E-mail:____

Insurance Coverage (Y/N) ___

Name of Insured ___________________________________

Date of Birth of Insured: ___/____/_____ Social Security of Insured:____-_____-______

Employer Name:____

Referred By:____

Medical History

Are you allergic to any drugs or medications? (Yes/No) If yes, please list_____________________

High blood pressure? (Yes/No) If yes, please list medication:_______________________________

A heart ailment, including mitral valve prolapse or heart murmur? (Yes/No)

Do you have a history of heart surgery? (Yes/No) If yes, please list:__________________________

Do you have Diabetes? (Yes/No)

Do you have Rheumatic fever? (Yes/No)

Do you have HIV or AIDS? (Yes/No) If yes, please list medication:__________________________

Do you have Hepatitis? (Yes/No) If yes, please list type:___________________________________

Have you ever had any radiation treatment? (Yes/No)

Do you have epilepsy, convulsions, or seizures? (Yes/No)

Do you have any pain in or near your ears? (Yes/No)

Are you pregnant? (Yes/No) If yes, how many months?___________

Are there any other conditions we should be aware of?____________________________________

Are you presently taking drugs or medications not listed above for any other medical condition? If yes, please
list:____

____

Dental History

Do you have or have you ever had any of the following: Please circle.

Bleeding, sore gums (Yes/ No)

Clenching/grinding? (Yes/ No)

Clicking/popping jaw? (Yes/ No)

Sensitive teeth (hot or cold)? (Yes/ No)

Teeth sensitive to sweets? (Yes/ No)

Orthodontic treatment (braces)? (Yes/ No)

Deep cleanings (Scaling/root planning) (Yes/ No)

Do you use the following? Please circle.

Toothbrush (Yes/ No) How often?______ Manual or Electric?

Toothbrush type is: (Soft) (Medium) (Hard)

Dental Floss? (Yes/ No) How often________

Is there anything about your teeth you would like to change?________________________________

____

Do you want whiter teeth?____

In case of emergency,notify:______________________________Phone Number:__________

Unless prior arrangements have been made, payment is expected at time of service.

In order to provide the best possible service, please notify us at least 24 hours in advance if you are not able to keep an appointment. Broken appointments will be subjected to a charge.

I certify that the above information is true and accurate to the best of my knowledge. I accept full financial responsibility for my account, including any fees which are assessed to my account to collect any outstanding balance.

Signature Date

____ ____/____/______