

PATIENT ACQUAINTANCE FORM

Date _____ Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Social Security# _____ Home Phone _____ Business Phone _____

Male Female Whom may we thank for referring you? _____

DENTAL HISTORY

- How long since you have been to the dentist? _____
- When was your last set of full mouth x-rays (16 or more films)? _____
- Have you ever been treated for periodontal disease (gum disease)? YES NO
- How often do you brush your teeth? _____
- Do your gums bleed when you brush? YES NO
- Have you ever had orthodontic treatment? YES NO
- Have you ever had injury to your face or jaws? YES NO
If yes, please explain _____
- Have you ever had a clicking or popping near your ear when you chew? YES NO
- Do you grind your teeth? YES NO
- Do you have sores, blisters or swelling on your gums, lips or cheeks? YES NO
- Have you ever had complications from an extraction? YES NO
If yes, please explain _____

MEDICAL HEALTH HISTORY

- Are you in good health? YES NO
- Date of last physical examination: _____
- Are you now under the care of a physician? YES NO
If yes, Physician's name: _____ Phone Number: _____
Address: _____
- Have you ever had any serious illness or had an operation? YES NO
- Have you ever been hospitalized? YES NO
- If so, when and what was the problem? _____
- Have you ever had a blood transfusion? YES NO
- Are you now taking any drugs or medicine? YES NO
If so, please list: _____
- Are you sensitive or allergic to any drugs (penicillin, tetracycline, sulfa drugs, codeine, aspirin, etc.)?
If so, please list: _____

MEDICAL HEALTH HISTORY (CONT.)

Do you have or have you had any other following (please check)

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis A (infectious) |
| <input type="checkbox"/> Heart Disease or Attack | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Hepatitis B (serum) |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Asthma or Hay Fever | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Ulcers | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Benign Tumor | <input type="checkbox"/> A.I.D.S. or A.R.C. |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cortisone Medicine | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis or Rheumatism | |

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- | | | |
|--|------------------------------|-----------------------------|
| ▪ Have you ever had any excessive bleeding requiring special treatment? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Have you ever been denied permission to donate blood? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Do your ankles swell during the day? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Do you smoke?
If so, how much _____ | | |
| ▪ Have you ever had a prolonged fever of unknown origin? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Have you ever had a prolonged, unexplained sore throat, cough, or swollen lymph glands? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Have you lost or gained more than 10 lbs. in the last year? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Do you ever wake up from sleep short of breath? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Are you on a special diet? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Do you have any disease, condition or problem not listed?
If so, please explain _____ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

FOR WOMEN ONLY

- | | | |
|--|------------------------------|-----------------------------|
| ▪ Are you pregnant now? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Are you taking birth control pills? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Do you anticipate becoming pregnant? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Are you nursing presently? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

PATIENT SIGNATURE

DATE

RESPONSIBLE PARTY INFORMATION

Name of person responsible for this account: _____

Address _____ City _____ State _____ Zip Code _____

Social Security# _____ Home Phone _____ Business Phone _____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

Insured's Name _____ Social Security # _____

Insured's Employer _____ Phone # _____

Insurance Company _____ Group No. _____

Insurance Co. Address _____

Insurance Co. Phone Number _____

Do you have another insurance coverage? YES NO

If yes: Please complete the following secondary insurance information.

SECONDARY INSURANCE

Insured's Name _____ Social Security # _____

Insured's Employer _____ Phone # _____

Insurance Company _____ Group No. _____

Insurance Co. Address _____

Insurance Co. Phone Number _____

CONSENT FOR TREATMENT

The undersigned hereby authorizes the health care provider to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment.

I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors and/or other health practitioners (See HIPAA Voluntary Consent Form).

I understand that insurance will be billed and submitted as a courtesy for me as your patient. Assignment of benefits from the insurance company will be paid directly to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand that all responsibility for payment for dental services provided in this office for myself or any of my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand a 1-1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.

I understand that it is my responsibility to advise your office of any changes in the information contained in this form.

PATIENT SIGNATURE or RESPONSIBLE PARTY

DATE