

ACQUAINTANCE FORM

It is important that we get to know about you including your dental and medical history. Many things have a direct bearing on our dental health. We will review this questionnaire and discuss it with you in detail. The information you give us is strictly confidential and will not be released to anyone without your permission.

PATIENT INFORMATION

Patient's Name _____
Address _____
Telephone _____ Social Security # _____ City _____ State _____ ZIP _____
Employer Name _____ Work Telephone _____
Marital Status _____ If Married, Spouse's Name _____
How Did You Happen To Choose Our Office? _____

EMERGENCY INFORMATION

In case of emergency contact _____
Address _____
Telephone _____ Relationship _____ City _____ State _____ ZIP _____

RESPONSIBLE PARTY INFORMATION

Person Responsible For Payment _____ Relationship _____
Address _____
Telephone _____ Social Security # _____ City _____ State _____ ZIP _____
Date of Birth _____

INSURANCE INFORMATION

Dental Insurance Company Name _____ Employer _____
Address _____
Group #: _____ Subscriber Name: _____ City _____ State _____ ZIP _____
SS# _____
IF DUAL COVERAGE - SECONDARY INSURANCE COMPANY:
Insurance Company Name _____ Employer _____
Address: _____ Group/Policy # _____
Relationship: _____ Subscriber Name: _____ SS# _____

MEDICAL HISTORY

(Please any of the following which you have or have had and explain where necessary)

- 1. AIDS
- 2. Anemias
- 3. Arthritis
- 4. Asthma
- 5. Autoimmune Problems _____
- 6. Birth Control Pills
- 7. Blood Clots
- 8. Blood Transfusions
- 9. Bone Problems _____
- 10. Cancer, Tumors _____
- 11. Dental Phobia
- 12. Depression
- 13. Diabetes
- 14. Diet Pill Problems _____
- 15. Digestion Problems
- 16. Epilepsy, Seizures
- 17. Fainting Spells
- 18. Hayfever, Allergies _____

- 19. Heart Problems
 - A. Cardiac Bypass Surgery
 - B. Cardiac Pacemaker
 - C. Congenital Heart Defects
 - D. Heart Attack
 - E. Heart Murmur
 - F. Mitral Valve Prolapse
 - G. Prosthetic Valve Surgery
- 20. Hepatitis, Liver Disease
- 21. High Blood Pressure
- 22. Jaundice
- 23. Joint Replacement _____
- 24. Kidney Problems _____
- 25. Low Blood Pressure
- 26. Lung Disease
- 27. Muscle Disease _____
- 28. Nervous Disorders
- 29. Rheumatic Fever
- 30. Social Disease _____
- 31. Steroid Hormone Therapy
- 32. Stroke
- 33. Thyroid Disorders
- 34. Tuberculosis/Symptoms
- 35. Other Diseases _____

Please list any medications you are taking:

Medication	Dosage/Regimen
_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to any of the following:

- Antibiotics Penicillin Erythromycin Tetracycline Sulfa Keflex Other _____
 Local Anesthetics _____ Narcotics _____ Aspirin Codeine Ibuprofen
 Latex Metals Other _____

Have you been advised to take medication before dental appointments? Y / N (circle) If so, please explain _____

Have you ever had a skin rash or other reaction to metal jewelry? Y / N (circle) To what? _____

Do you wear contact lenses? Y / N (circle)

Have you been a patient in a hospital in the past two years? Y / N (circle) If so, please explain _____

Last medical visit _____ (date) _____ (reason)

Physician's name, address and telephone number _____

Have you ever had a problem with anesthesia? _____ General _____ Novocaine _____

Do you have reason to believe that you are at risk of contracting infectious or sexually transmitted diseases? Y / N (circle)
If so, please explain _____

Have you ever received counseling for excessive use of alcohol and/or prescription drugs? Y / N (circle)

Do you bleed excessively upon injury? Y / N (circle)

Is there a possibility that you might be pregnant? Y / N (circle) If yes, how many months? _____

Do you drink alcohol? Y / N (circle) _____ oz/day _____ oz/week _____ oz/month

Do you smoke? Y / N (circle) cigarettes/day _____ cigars _____ pipes _____ chewing tobacco _____ snuff _____

Are you experiencing stress or pressure in your work or at home? Y / N (circle)

Are you in a job that exposes you regularly to x-rays or radiation? Y / N (circle)

Is there anything other in your medical history that we have missed? _____

DENTAL HISTORY

- How long has it been since you have been to a dentist? _____
- What service was rendered? _____
- Were x-rays taken? _____
- Did you have regular cleanings? _____
- Have you lost teeth? _____ Why? _____
- Have you ever had complications with extractions? _____
- How often do you brush your teeth? _____ X/day AM _____ PM _____ Do you use floss? _____ Other hygiene aids? _____
- Do your gums ever bleed? _____ When? _____
- Does food collect or wedge between your teeth? _____
- Do you have an unpleasant taste in your mouth? _____
- Are your teeth sensitive? _____ Sweets? _____ Cold? _____ Hot? _____ Pressure? _____
- Do you grind or clench your teeth? _____
- Do you have popping or clicking sounds when you open/close your mouth? _____
- Do you get headaches? _____ Frequency? _____ When do they come? _____

TREATMENT AUTHORIZATION

I consent to whatever dental procedures and anesthetics are necessary for treatment. I also understand that payment is my obligation regardless of insurance or any other third party involvement.

Signature of patient or guardian _____ Date _____

Signature of Dentist _____ Date _____