Form 001 11/13

Patient Acquaintance Form

Patient Info: Full Name: ________________________ Today's Date:________________
Preferred Name______________________________ Birthdate ______________________________ Sex: M F
( ) Single ( ) Married ( ) Sep. ( ) Div. ( )Wid. ( ) Dep. Child **Soc. Security #**_________________
Address:_________________________________ City:_________________ State:_______ Zip:_____________
Phone: **Home #**_________________________ **Work #**_____________________ **Cell #**__________________
Optional ways to reach you: FAX #_________________ **Email** address: ___________________________
Name of close friend or relative **NOT** living with you in case of emergency: ___________________________
Phone #:____ Relationship:____________________________
Whom may we thank for referring you to our office? _________________ Relationship _______________

If patient is a minor, please list school and city ____

Insured employee's name _______________________
Occupation______________________________________
Drivers License #________________________________
Dental Insurance Co. ____________________________
Group # _______________________________________

Company Name _________________________
Social Security # _________________________
Birthdate _______________________________
Dental Insurance phone #__________________
Please provide our office with your ID card.

Patients with DUAL insurance fill out the following:
Name of Insured _______________________________
Social Security # _______________________________
Dental Insurance Co. ____________________________
Group # _______________________________________

Relation to insured: ( ) self ( ) spouse ( ) child
Employer ______________________________
Birthdate _______________________________
Dental Insurance phone#__________________
Please provide our office with your ID card.

Former dentist____________________ City___________________ Date of last dental visit _______________
Purpose of today's visit: Check up/ Cleaning?_________ Toothache?_________ Consultation?___________

ACKNOWLEDGEMENT:

As a courtesy to our patients, we will assist you in the preparation of your insurance forms so that you may receive the maximum benefits as designed by your insurance plan. Please understand that our services are rendered to you and not your insurance company, and therefore, you are ultimately responsible for the payment of your account regardless of any insurance stipulations. Please take responsibility to understand the benefits and limitations of your specific plan as purchased by your employer for you. Unless other financial arrangements are made, payment will be expected prior to beginning treatment. Accounts that are ninety days past due may be subject to a service charge of 1 ½% per month.

I hereby authorize said assignee to release all information necessary to secure payment, and agree to allow this office to use whatever treatment, diagnoses techniques, and medications are normally used in carrying out the appropriate care for the above-named patient. I understand that treatment options and medications will be discussed and reviewed, prior to being implemented. I also understand it is my responsibility to keep the appointments made with this office and that there may be a charge for recurrent broken appointments.

Signed____ Date________________________
(Patient or responsible party)

* **Please complete BOTH pages** *

Medical History Update

Have you or do you currently have any of the following? Please check yes or no.

Yes No	Yes No	Yes No	Yes No Allergies /reaction to:
[ ] [ ] Asthma / Bronchitis	[ ] [ ] Nose Obstruction	[ ] [ ] Rheumatic Fever	[ ] [ ] Penicillin
[ ] [ ] Abnormal heart condition	[ ] [ ] Headaches / ear pain	[ ] [ ] Mitral valve prolapse	[ ] [ ] Novocain
[ ] [ ] Anemia/ Hemophilia	[ ] [ ] Recent cold /flu	[ ] [ ] Heart Murmur	[ ] [ ] Erythromycin
[ ] [ ] Bruise Easily	[ ] [ ] Epilepsy / Fainting	[ ] [ ] Artificial heart valve	[ ] [ ] Tetracycline
[ ] [ ] Hepatitis A (infectious)	[ ] [ ] Radiation Therapy	[ ] [ ] Surgical implant	[ ] [ ] Codeine
[ ] [ ] Hepatitis B (serum)	[ ] [ ] Chemotherapy	[ ] [ ] Artificial pacemaker	[ ] [ ] Aspirin
[ ] [ ] Convulsions	[ ] [ ] Sinus Trouble	[ ] [ ] Prosthetic joint	[ ] [ ] Sulfa
[ ] [ ] Liver Disease	[ ] [ ] Ulcers / Cold Sores	[ ] [ ] High blood pressure	[ ] [ ] Epinephrine
[ ] [ ] Kidney Disease	[ ] [ ] Psychiatric Treatment	[ ] [ ] Low blood pressure	[ ] [ ] Hay Fever
[ ] [ ] Drug Addiction	[ ] [ ] Herpes	[ ] [ ] Congenital heart lesion	[ ] [ ] Latex or other medicine:
[ ] [ ] Arthritis / Diabetes	[ ] [ ] Abnormal Bleeding	[ ] [ ] AIDS/ HIV positive	Have you ever taken?
[ ] [ ] Glaucoma	[ ] [ ] Emphysema / Tuberculosis	[ ] [ ] High Cholesterol	[ ] [ ] Fen Phen/Bisphosphonates
[ ] [ ] Cancer / Stroke	[ ] [ ] Snoring / Sleep Apnea	[ ] [ ] Venereal Disease	other allergies?______________

MEDICAL DOCTOR NAME______________________________ **PHONE NUMBER**__________________

	Yes	No	
Do you consider yourself in good health?	☐	☐	________________________
Are you currently under a physicians care?	☐	☐	________________________
Have you been hospitalized in the last 5 years?	☐	☐	________________________
Are you currently taking any medications?	☐	☐	________________________
Are you currently taking any nutritional supplements (vitamins)? …...	☐	☐	________________________
Do you smoke? …………………………………………………………..	☐	☐	________________________
Any serious medical conditions we should know about? ……………..	☐	☐	________________________
Women only: Are you pregnant? ……………………………………..	☐	☐	Due date: ______________________
Are you breast feeding? ………………………………..	☐	☐	O.B. Dr.________________________
Do you take birth control pills? ………………………..	☐	☐	_________________ explain rxn ☐

DENTAL HISTORY

	Yes	No	
Do you have any current dental complaints?	☐	☐	________________________
Do you need special premedication for dental work? ………………...	☐	☐	________________________
Do you have special concerns about your dental care? ……………….	☐	☐	________________________
Do you clench or grind your teeth?	☐	☐	________________________
Do you have frequent tension headaches? ....………………...	☐	☐	________________________
Are you missing any teeth?	☐	☐	________________________
Are you happy with the appearance of your smile?	☐	☐	________________________
Would you like Doctor to explain some of the new advances in cosmetic dentistry to you?..................................	☐	☐	________________________
Have you had orthodontics (braces)? …………………………………	☐	☐	________________________
Have you been treated by a periodontist? (Gum specialist)……………	☐	☐	________________________
Do you have any teeth that are sensitive? (hot, cold, pressure)……….	☐	☐	________________________
Do your gums bleed when you floss or brush? ……………………….	☐	☐	________________________

The above is true and accurate and I will let Doctor know when anything on this form changes.

PATIENT/GUARDIAN Signed______________________________________ Date__________________

STAFF: Updated ______________________ *Updated* ________________________ *Updated* ______________________