Patient Acquaintance Form

Patient Info:

Full Name_____ Today's Date_____
Last First Middle Initial

Name you preferred to be called _____ Birthdate _____

Sex: M / F ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed ( ) Dependent Child

Address: _____City _____ State _____ Zip _____

Phone: Home# _____ Work# _____ Cell# _____

Patient's occupation _____ Employer _____

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 _____

Patient's with insurance should fill out the following: Relation to Insured: ( ) self ( ) spouse ( ) child

Name of Insured _____ Employer _____

Birthdate _____ Address _____

Group/Policy# _____ Social Security# _____

Local#/Employee# _____ Driver's License# _____

Patient's with **DUAL** insurance fill out the following: Relation to Insured: ( ) self ( ) spouse ( ) child

Name of Insured _____ Employer _____

Birthdate _____ Address _____

Group/Policy# _____ Social Security# _____

Local#/Employee# _____ Driver's License# _____

Former dentist's name _____ Date of last dental visit _____

Purpose of today's visit: Check up/Cleaning? _____ Toothache? _____ Consultation? _____

Physician's (Medical Doctor) name: _____ Phone# _____

Reason for last medical visit _____ Kaiser# _____

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 individual plan. Please understand that the services are rendered to you and not your insurance company, and therefore, you are ultimately responsible for the payment of our account regardless of any insurance stipulations. Please take the 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 at the time of the visit. Accounts that are over 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, diagnosis techniques, and medications as 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)

Medical History Update

Have you had 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			Novocaine
		Anemia / Hemophilia			Recent Cold / Flu			Heart murmur			Erythromycin
		Diabetes			Epilepsy / fainting			Artificial heart valve			Tetracycline
		Hepatitis A (infections)			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			Other medicines:
		Drug addition			Herpes			Congenital heart lesion			
		Arthritis			Abnormal bleeding			AIDS / HIV positive			Hay fever
		Glaucoma			Emphysema			High Cholesterol			Latex
		Cancer / stroke			Tuberculosis			Venereal disease			Other:
								Fen Fen			

	Yes / No	Explain
Do you consider yourself in good health?	( ) ( )	_____
Are you currently under a physician's care?	( ) ( )	_____
Have you been hospitalized in the last 5 years?	( ) ( )	_____
Are you currently taking any medications?	( ) ( )	_____
Are you taking any nutritional supplements (Vitamins, etc.)	( ) ( )	_____
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?	( ) ( )	_____

DENTAL HISTORY	Yes / No	
Do you have any current dental complaints?	( ) ( )	_____
Do you need special premedication for dental work?	( ) ( )	_____
Do you have any 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 the Doctor know when anything on this form changes.

Signed _____ Date _____

Office use

Reviewed by: _____ Date _____ BP: _____ Pulse: _____ Resp: _____

Updated _____ Updated _____

Updated _____ Updated _____