ACQUAINTANCE CARD AND DENTAL HISTORY

PATIENT INFORMATION

Patient's Name_____ Date of Birth_____

Do you go by another name? _____ If Child, Parent's name_____

Sex:___ Male ___Female Status:___Single ___ Married ___ Divorced ___Widowed

Home Address:_____
Street Address City State Zip

Home Phone Number:_____Cell Number:_____Work Number:_____

Email Address:_____What is the best way to reach you? _____

Patient's Employer:_____ Occupation:_____

Name of person to contact in case of an Emergency:_____Phone:_____

Whom may we thank for referring you to our practice?_____

DENTAL INSURANCE INFORMATION

Do you have dental insurance? ___Yes ___No If Yes, Name of Insurance Company_____

Do you have an insurance card? ____Yes ____No Please note: If you DO NOT have Insurance information including ID number, group number and claims mailing address we will NOT be able to submit claims on your behalf.

Name of Insured:_____

Insured's Date of Birth_____ Insured's Social Security #_____

Relationship to patient:_____ Insured's Address _____

Insured's Employer:_____Work phone number_____

DENTAL HISTORY

Why have you come to the dentist today?_____

Are you currently in pain? ____Yes ___No If yes, please describe_____

Have you experienced problems associated with previous dental care ___Yes ___ No
If yes, please explain:_____

Are your teeth sensitive? ___Yes ___No Would you like whiter teeth? ___Yes ___No

Do you use Tobacco products? ___Yes ___No If yes, what type and how much_____

Have you ever had: ____Orthodontics ___ Periodontal Treatment ___Oral Surgery

RESPONSIBLE PARTY

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I authorize this office to bill my dental insurance. I understand that I am responsible for this bill should my insurance not pay. I authorize insurance payments to be made directly to this dental office. I understand that if I fail to honor my payment arrangements and/or default in payment that I may be turned over to a collection agency at the discretion of this office.

SIGNATURE: _____ Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices.

SIGNATURE: _____ Date_____

MEDICAL HISTORY

Patient's Name:_____ Age:_____

Name of your Physician: _____ Approximate Date of last exam:_____

Please list all current MEDICATIONS that you are taking including over the counter medications:

_____
_____
_____
_____

Have you ever had any of the following diseases or medical problems? (Please Circle Y or N)

Y N **Acid Reflux**
Y N **Anorexia / Bulimia**
Y N **Artificial Joints**
Type_____
Date_____
Y N **Blood Disorders**
Y N Anemia
Y N Bruise Easily
Y N Excessive Bleeding
Y N Hemophilia
Y N High Blood Pressure
Y N Low Blood Pressure
Y N **Cancer**
Type_____
Date_____
Y N Chemotherapy
Y N Radiation

Y N **Diabetes** Type_____
Y N **Drug Addiction**
Y N **Epilepsy**
Y N Fainting Spells
Y N Seizures
Y N **Glaucoma**
Y N **Heart Problems**
Y N Angina (Chest Pain)
Y N Heart Attack
Y N Mitral Valve Prolapse
Y N Murmur
Y N Rheumatic fever
Y N Pacemaker
Y N Stents
Y N Stroke
Y N Heart Surgery Date_____
Type_____
Y N Other_____

Y N **Hepatitis**
Type_____
Y N **Herpes/Cold Sores**
Y N **HIV+ / AIDS**
Y N **Kidney Disease**
Y N **Lung Disease**
Y N Asthma
Y N Emphysema
Y N **Osteoporosis**
Y N **Pain Management**
Y N **Psychiatric Treatment**
Y N **Sinus Problems**
Y N **Thyroid Disease**
Y N **Tuberculosis**

Please list any other conditions not listed:

_____
_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Y N Latex
Y N Dental Anesthetics
Y N Clindamycin
Y N Amoxicillin
Y N Penicillin
Y N Erythromycin

Please list any other drugs you are allergic to:

_____
_____

FOR WOMEN ONLY

Are you pregnant? Y N If Yes, Week #____
Are you Nursing? Y N
Are you Taking Birth Control Pills? Y N
If Yes, Do you understand that Antibiotics may reduce the effectiveness of birth control pills? Y N

To the best of my knowledge, all of the information on this form is correct and true. If there are any changes in my health status, or my medications, I will inform the doctor prior to treatment. I also understand that this information will be held in the strictest confidence.

Signature_____**Date**_____

OFFICE USE ONLY

Is pre-med required for this patient? _____ **Rx:** _____

Medical History Update: I have reviewed the patient's medical history and the above (including any changes) is accurate.

Date_____ Initials_____ Comments_____
Date_____ Initials_____ Comments_____
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