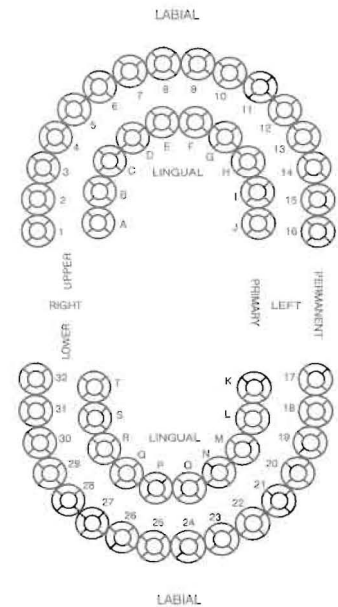


PATIENT ACQUAINTANCE FORM

Please print the following information  
This information is important for our records and your health.

MEDICAL – DENTAL HISTORY

PATIENT \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
 LAST NAME (MR, MRS, MISS) FIRST NAME  
 NAME OF SPOUSE / PARENT \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_  
 LAST NAME FIRST NAME PATIENT'S AGE TEL. NO. \_\_\_\_\_  
 CELL NO. \_\_\_\_\_  
 RESIDENCE ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
 PERSON RESPONSIBLE FOR PAYMENT \_\_\_\_\_  
 NAME OF INSURANCE COMPANY \_\_\_\_\_  
 SOCIAL SECURITY NO. OF PERSON RESPONSIBLE FOR PAYMENT \_\_\_\_\_  
 DRIVER'S LICENSE NUMBER \_\_\_\_\_  
 EMPLOYED BY: Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Business Phone \_\_\_\_\_  
 OCCUPATION \_\_\_\_\_  
 REFERRED BY \_\_\_\_\_  
 NAME OF MEDICAL DOCTOR \_\_\_\_\_  
 WHAT IS YOUR PRESENT DENTAL PROBLEM? \_\_\_\_\_



- Please answer each question
- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Are you in good health .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you now or have you ever been under the care of a medical doctor during the past two years, except for routine check ups .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Circle any of the following which you have had or have at the present:<br>Heart Trouble, High Blood Pressure, Diabetes, Hepatitis, AIDS, Asthma, Spina Bifida, Epilepsy, Rheumatic Fever, Tuberculosis, Kidney, Liver Involvement, HIV or Cancer ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you taking medication now .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever taken Phen/Fen, Fosamax or other osteoporosis medications? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you pregnant .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you subject to any nervous disorders, fainting or dizziness .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever experienced any ill effect from novocaine, penicillin, codeine or any other drug .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever had any trouble with excess bleeding or allergy to latex .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you experienced any unfavorable reaction from any previous dental treatment .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. When was your last dental checkup _____   |                          |                          |
| 12. When was the last time you received a full mouth x-ray _____  |                          |                          |
| 13. Is there any other health condition I should be informed of _____   |                          |                          |

I consent to whatever dental procedures and anesthetics are necessary for treatment

I have received a copy of the Dental Materials Fact Sheet as required by law.

PATIENT'S SIGNATURE (PARENT OR GUARDIAN IF A MINOR)

Signature

Date