PATIENT ACQUAINTANCE FORM

Please print the following information

This information is important for our records and your health.

PATIENT _____ BIRTHDATE _____

LAST NAME (MR, MRS, MISS) FIRST NAME

NAME OF SPOUSE / PARENT _____ PATIENT'S AGE _____ TEL. NO. _____

LAST NAME FIRST NAME CELL NO. _____

EMAIL ADDRESS _____

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	☐	☐
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	☐	☐
3. Circle any of the following which you have had or have at the present: Heart Trouble, High Blood Pressure, Diabetes, Hepatitis, AIDS, Asthma, Spina Bifida, Epilepsy, Rheumatic Fever, Tuberculosis, Kidney, Liver Involvement, HIV or Cancer	☐	☐
4. Are you taking medication now	☐	☐
5. Have you ever taken Phen/Fen, Fosamax or other osteoporosis medications?	☐	☐
6. Are you pregnant	☐	☐
7. Are you subject to any nervous disorders, fainting or dizziness	☐	☐
8. Have you ever experienced any ill effect from novocaine, penicillin, codeine or any other drug	☐	☐
9. Have you ever had any trouble with excess bleeding or allergy to latex	☐	☐
10. Have you experienced any unfavorable reaction from any previous dental treatment	☐	☐

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

MEDICAL – DENTAL HISTORY