

# PATIENT ACQUAINTANCE FORM

Date \_\_\_\_\_ Whom may we thank for referring you to our office? \_\_\_\_\_  
Name \_\_\_\_\_ Nickname \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
 Male  Female Email: \_\_\_\_\_ Social Security # \_\_\_\_\_

## DENTAL HISTORY

- When was your last dental visit? \_\_\_\_\_
- When was your last set of full mouth x-rays taken? \_\_\_\_\_
- How often do you brush / floss your teeth? \_\_\_\_\_
- Do your gums bleed when you brush or floss?  Yes  No
- Have you ever been treated for periodontal disease (gum disease)?  Yes  No
- Have you ever had orthodontic treatment?  Yes  No
- Have you ever had injury to your face or jaws?  Yes  No  
If yes, please explain \_\_\_\_\_
- Do you ever have clicking, popping or discomfort in your jaw joints?  Yes  No
- Do you grind / brux or clench your teeth?  Day or  Night  Yes  No
- Do you have sores, blisters or swelling on your gums, lips or checks?  Yes  No

## MEDICAL HEALTH HISTORY

Do you have or have you had any of the following? Please check the appropriate boxes.

***\*If yes to any of the starred conditions, please call prior to your appointment...premedication may be required.***

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Heart Failure             | <input type="checkbox"/> Emphysema               | <input type="checkbox"/> Hepatitis Type A B C  |
| <input type="checkbox"/> Heart Disease or Attack   | <input type="checkbox"/> Tuberculosis (TB)       | <input type="checkbox"/> High Risk             |
| <input type="checkbox"/> Angina Pectoris           | <input type="checkbox"/> Asthma or Hay Fever     | <input type="checkbox"/> Liver Disease         |
| <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Sinus Trouble           | <input type="checkbox"/> Yellow Jaundice       |
| <input type="checkbox"/> Heart Murmur*             | <input type="checkbox"/> Allergies or Hives      | <input type="checkbox"/> Drug Addiction        |
| <input type="checkbox"/> Rheumatic fever*          | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Hemophilia            |
| <input type="checkbox"/> Congenital Heart Lesions* | <input type="checkbox"/> Thyroid Disease         | <input type="checkbox"/> Venereal Disease      |
| <input type="checkbox"/> Scarlet Fever             | <input type="checkbox"/> Radiation Therapy       | <input type="checkbox"/> Epilepsy or Seizures  |
| <input type="checkbox"/> Artificial Heart Valve*   | <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Nervousness           |
| <input type="checkbox"/> Heart Pacemaker*          | <input type="checkbox"/> Pain in Jaw Joints      | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Heart Surgery             | <input type="checkbox"/> Bruise Easily           | <input type="checkbox"/> Sickle Cell Disease   |
| <input type="checkbox"/> Mitral Valve Prolapse*    | <input type="checkbox"/> Kidney Trouble          | <input type="checkbox"/> Leukemia              |
| <input type="checkbox"/> Artificial Joint*         | <input type="checkbox"/> Ulcers                  | <input type="checkbox"/> HIV                   |
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Benign Tumor            | <input type="checkbox"/> A.I.D.S. or A.R.C.    |
| <input type="checkbox"/> Stroke                    | <input type="checkbox"/> Cortisone Therapy       | <input type="checkbox"/> Other                 |
| <input type="checkbox"/> Cancer _____              | <input type="checkbox"/> Arthritis or Rheumatism |  |

# MEDICAL HEALTH HISTORY

- Are you in good health?      Date of last physical examination: \_\_\_\_\_  Yes  No
- Are you now under the care of a physician?  Yes  No  
Physician's name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Kaiser Medical # \_\_\_\_\_
- Have you ever had any serious illness or had an operation? \_\_\_\_\_  Yes  No
- Have you ever been hospitalized? If so, when and what was the problem \_\_\_\_\_  Yes  No
- Are you now currently taking any prescription medications or drugs?  Yes  No  
If so, please list: \_\_\_\_\_
- Are you **ALLERGIC** to any medications or substances? \_\_\_\_\_  Yes  No  
 Aspirin     Penicillin     Codeine     Acrylic     Metal     Latex Rubber     Sulfa     \_\_\_\_\_
- Have you ever had any excessive or prolonged bleeding requiring special treatment?  Yes  No
- Have you ever been denied permission to donate blood?  Yes  No
- When you walk up stairs or take a walk, do you ever have to stop because of a pain in your chest, shortness of breath, or because you are very tired?  Yes  No
- Do your ankles swell during the day?  Yes  No
- Do you smoke or chew tobacco? If so, how much and for how long? \_\_\_\_\_  Yes  No
- Are you on a special diet?  Yes  No
- Do you have any disease, condition or problem not listed?  Yes  No  
If so, please explain \_\_\_\_\_

## FOR WOMEN ONLY

- Are you pregnant now? What trimester \_\_\_\_\_  Yes  No
- Are you taking birth control pills?  Yes  No
- Do you anticipate becoming pregnant?  Yes  No
- Are you nursing presently?  Yes  No

## ADDITIONAL COMMENTS

---

---

---

I understand the above information is necessary to provide me with dental care in a safe and careful manner. I have answered all questions truthfully and to the best of my knowledge.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
DENTIST SIGNATURE

\_\_\_\_\_  
DATE

# RESPONSIBLE PARTY INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Soc. Sec. \_\_\_\_\_

If patient is a full time student? Name of school \_\_\_\_\_ State \_\_\_\_\_

Name of person responsible for this account: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home # \_\_\_\_\_ Business # \_\_\_\_\_ Cellular # \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone # \_\_\_\_\_

## DENTAL INSURANCE INFORMATION

### PRIMARY INSURANCE

Insured's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Soc Sec. \_\_\_\_\_

Insured's Employer \_\_\_\_\_ Phone # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Insurance ID No. \_\_\_\_\_ Insurance Co. Phone # \_\_\_\_\_

Do you have another insurance coverage?  Yes  No

If yes, Please complete the following secondary insurance information.

### SECONDARY INSURANCE

Insured's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Soc. Sec. \_\_\_\_\_

Insured's Employer \_\_\_\_\_ Phone # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Insurance ID No. \_\_\_\_\_ Insurance Co. Phone # \_\_\_\_\_

## CONSENT FOR TREATMENT

The undersigned hereby authorizes the health care provider to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs and treatment. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment.

I authorize the dentist to release any information including diagnosis and the records of any treatment of examination rendered to me during the period of such dental care to third party payors and/or other health practitioners.

I understand that my insurance(s) will be billed and submitted as a courtesy to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand that all responsibility for payment for dental services provided in this office for myself or any of my dependents is mine, due and payable at the time services are rendered unless other financial arrangements have been made. In the event payments are not received by the agreed upon dates, I understand a 1 ½ % finance charge (18% APR) may be added to my account, in addition to any collection fees. I understand that any appointment cancelled with less than 48 hrs. notice is subject to charge. I understand that it is my responsibility to advise your office of any changes in the information contained in this form.

\_\_\_\_\_  
PATIENT SIGNATURE OR LEGAL GUARDIAN

\_\_\_\_\_  
DATE