

Patient Get Acquainted Form

Date _____

Patient Information

Patient Name _____
Last First Middle Nickname

Patient's Address _____
Street City State Zip

Home (____) _____ Birth Date _____ Patient's Social Security Number ____ - ____ - _____

Patient's Employer _____

If Student, name of school _____

Spouse's Name _____ Home (____) _____ Employer _____ Work (____) _____

Name of Responsible Party (person responsible for account, if different)

Name _____ Home (____) _____ Work (____) _____

Address of responsible party _____

Two people to contact in case of an emergency 1. _____ (____) _____

2. _____ (____) _____

Whom may we thank for referring you to our office?

Former Dentist _____ Date of last treatment _____

Insurance Information

If you are covered by Dental insurance, please complete this section

Name of insured person _____

Employer of insured person _____

Address of employer _____

Name of insurance company _____

Address of insurance company _____

Group policy number _____ Union Local _____

Insured person's birth date _____ Insured's Social Security Number ____ - ____ - _____

Dual Insurance Information

If you are covered by more than one policy, please complete this section

Name of insured person _____

Employer _____

Address of employer _____

Name of insurance company _____

Address of insurance company _____

Group policy number _____ Union Local _____

Insured person's birth date _____ Insured's Social Security Number ____ - ____ - _____

MEDICAL HISTORY

CIRCLE

- | | | |
|--|-----|----|
| 1. Do you habitually clench your teeth during the night or day? | YES | NO |
| 2. Are you having pain or discomfort at this time? | YES | NO |
| 3. Do you feel very nervous about having dentistry treatment? | YES | NO |
| 4. Have you ever had a bad experience in the dentistry office? | YES | NO |
| 5. Have you been a patient in the hospital during the past two years? | YES | NO |
| 6. Have you been under care of a medical doctor during the past two years? | YES | NO |

Physician's Name _____

Address _____ Phone (_____) _____

- | | | |
|--|-----|----|
| 7. Have you taken any medicine or drugs during the past two years? | YES | NO |
|--|-----|----|

8. If yes, please list those drugs:

Aspirin	Nitrous Oxide	Valium	Penicillin
Darvon	Erythromycin	Scopolamine	Other Antibiotics
Codeine	Tetracycline	Local Anesthetic	(Novacaine or Xylocaine)
Demerol	Percodan	Nembutal/Seconal	(Sleeping Pills)

- | | | |
|--|-----|----|
| 9. Are you aware of being allergic to any other medication or substance? | YES | NO |
|--|-----|----|

If yes, please list: _____

10. Circle any of the following which you have had or have at present:

Heart Failure	Emphysema	Artificial Joints (Hip, Knee)
Heart Disease or Attack	Cough	Hepatitis A (infectious)
Angina Pectoris	Tuberculosis (TB)	Hepatitis B (serum)
High Blood Pressure	Asthma	Liver Disease
Heart Murmur	Hay Fever	Yellow Jaundice
Rheumatic Fever	Sinus Trouble	Blood Transfusion
Congenital Heart Lesions	Allergies or Hives	Drug Addiction
Scarlet Fever	Diabetes	Hemophilia
Artificial Heart Valve	Thyroid Disease	Venereal Disease (Syphilis, Gonorrhea)
Heart Pacemaker	X-Ray or Cobalt Treatment	Cold Sores
Heart Surgery	Chemotherapy (Cancer, Leukemia)	Fever Blisters
Artificial Joint	Arthritis	Epilepsy or Seizures
Anemia	Rheumatism	Fainting or Dizzy Spells
Stroke	Cortisone Medicane	Nervousness
Kidney Trouble	Glaucoma	Psychiatric Treatment
Ulcers	Pain in Jaw Joints	Sickle Cell Disease
		Bruise Easily

- | | | |
|---|-----|----|
| 11. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired?..... | YES | NO |
| 12. Do your ankles swell during the day? | YES | NO |
| 13. Do you use more than two pillows to sleep? | YES | NO |
| 14. Have you lost or gained more than ten pounds in the past year? | YES | NO |
| 15. Do you ever wake up from sleep short of breath? | YES | NO |
| 16. Are you on a special diet? | YES | NO |
| 17. Has your medical doctor ever said you have a cancer or tumor? | YES | NO |
| 18. Do you have any disease, condition, or problem not listed? | YES | NO |

FOR WOMEN ONLY:

Are you pregnant? YES NO If yes, what month? _____ Are you taking birth control pills? YES NO

CONSENT:

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependants is mine, due and payable at the time services are rendered, unless financial arrangements have been made. In the event of default I (We) promise to pay legal interest on the Indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

Reviewed by _____