

ACQUAINTANCE FORM & HEALTH HISTORY

∞ Patient Information ∞

Name: _____

Gender (M/F): _____ Birth Date: _____ Marital Status (M/S): _____

Social Security #: _____ Driver's License #: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Name of employer: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Work Phone: _____

How would you like to receive confirmation of your appointment? E-mail Text Phone

Name of Person or Other Source Referring You to Our Practice:

Friend (Name: _____) Doctor (Name: _____)

Advertisement(_____) Internet Direct-mail Neighbor

Others(_____)

∞ Insurance Information ∞

Name of Insurance Company: _____ Name of Insured: _____

Patient's Relationship to Insured: _____

Insured's Employer Name: _____ Insured's Social Security #: _____

Employer's Address: _____ Insured's Date of Birth: _____

Insured's Employer Tel #: _____

∞ Dental History & Other Information ∞

Date of Last Dental Visit:	Where?:	Yes	No
01. Do you have pain in or near your ears?		_____	_____
02. Do you have any unhealed injuries or inflammation in mouth?		_____	_____
03. Does any part of your mouth hurt when clenched?		_____	_____
04. Do you have any sore spots or tenderness in the mouth?		_____	_____
05. Any experience with dental anesthesia in the past?		_____	_____
06. Any allergic reactions to dental anesthesia?		_____	_____
07. Any difficult extractions in the past?		_____	_____
08. Prolonged bleeding following extractions in the past?		_____	_____

	Yes	No
09. Are you under any medical treatment now?	_____	_____
10. Have you had any major operations? If so what? When? _____ What? _____	_____	_____
11. Have you had any serious head injuries?	_____	_____
12. Have you had any adverse reactions to any drugs?	_____	_____
13. Have you ever had any of the following?	_____	_____
	Heart ailment/Heart attack?	_____
	Stroke?	_____
	Pacemaker?	_____
	High blood pressure?	_____
	Respiratory disease?	_____
	Asthma?	_____
	Sinus Problems?	_____
	Tuberculosis?	_____
	Diabetes?	_____
	Rheumatic fever?	_____
	Rheumatism, arthritis or artificial Joints?	_____
	Tumors or cancers?	_____
	Any blood disease?	_____
	Anemia?	_____
	Any liver disease, hepatitis, Jaundice?	_____
	Any kidney disease?	_____
	Any stomach or intestinal disease?	_____
	Any venereal disease?	_____
	Epilepsy?	_____
	Glaucoma?	_____
	Excessive Bleeding?	_____
	HIV/AIDS?	_____
	Mental Disorders?	_____
	Nervous Disorders?	_____
	Chronic cough?	_____
	Codeine allergy?	_____
	Penicillin/Amoxicillin allergy?	_____
14. Do you have night sweats or any weight loss?	_____	_____
15. Are you on a diet at this time?	_____	_____
16. Are you taking drugs or medications?	_____	_____
17. Drugs or Medications you are presently taking?	_____	_____
18. Are you allergic to any known materials (Ex. latex)?	_____	_____
19. Have any wounds healed slowly or any complications?	_____	_____
20. Do you have a history of fainting?	_____	_____
21. Have you had any X-ray treatment for tumors?	_____	_____
22. (For Women) Are you pregnant? Due Date: _____	_____	_____
23. Are you in a habit of smoking?	_____	_____
24. Are you in general good health at this time?	_____	_____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient examination. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian _____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party _____ Date: _____ Relationship to Patient: _____

CLEAR

PRINT