Shi·MI·zu
GENERAL & AESTHETIC DENTISTRY

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 ALL

PRINT