ACQUAINTANCE FORM

It is important that we get to know about you including your dental and medical history. many things have a direct bearing on our dental health. We will review this questionnaire and discuss it with you in detail. the information you give us is strictly confidential and will not be released to anyone without your permission.

PATIENT INFORMATION

Patient's Name________________________________Email address______________________

Address____

Telephone: Home__________Cell_________Social Security #____________Date of Birth_________

Employer Name_____________________________Work Telephone______________________

Marital Status_________If Married, Spouse's Name______________________________________

EMERGENCY INFORMATION

In Case of Emergency Contact________________________ Relationship ___________________

Address____Telephone_______________

INSURANCE INFORMATION

Dental Insurance Company Name ____

Address____

Group #_____________Subscriber Name____________________Social Security #______________

IF DUAL COVERAGE--THE SECONDARY INSURANCE COMPANY:

Insurance Company Name_________________________Employer__________________________

Address______________________________________Group #/Policy #____________________

Relationship_______Subscriber Name_______________________Social Security #_____________

MEDICAL HISTORY *Please check or circle any of the following which you **have** or **have had** and explain where necessary. List pharmaceuticals (**prescribed medications**) you are taking now for this problem.*

□1 . AIDs____

□2. Anemias or Blood Discrasias____

□3. Arthritis, Rheumatoid or Osteo___________________________ _______________________

□4. Asthma____

□5. Autoimmune Problems____

□6. Birth Control Pills, Hormone Replacement Therapy or Fertility Problems________________________

□7. Blood Clots or Stroke: Y/N Treatment: ____

□8. Bone Problems, Osteoporosis
Treatment w/Bisphosphonates(Please circle or write): Fosamax Actonel Boniva Zometa oral or injection
Other:_______________________

□9. Cancer or Tumors: Y/N Current Treatment:________________ Previous Treatment:______________

□10. Depression or Nervous Disorders____

☐11. Diabetes: Type I or Type II

☐A. Oral Medication____________________ ☐B. Insulin Injections____________________________

☐12. Digestion Problems, Acid Relux, GERD____

☐13. Epilepsy or Seizures: Y/N Last episode:____

☐14.Hayfever or Allergies other than medications____

☐15.Heart Problems____

☐A. Cardiac Bypass Surgery________________________☐B. Cardiac Pacemaker________________

☐C. Congenital Heart Defect________________________ ☐D. Prosthetic Heart Valve______________

☐E. Heart Attack___________________________☐F. Heart Murmur, Mitral Valve Prolaspe__________

☐16. Hepatitis A,B, C or Liver Disease____

☐17.High Blood Pressure________________________________ ☐18. Low Blood Pressure____________

☐19. Joint Replacement________________________________ Premedication: Y/N Antibiotic:______________

☐20. Kidney Problems____

☐21. Lung Disease, COPD____

☐22. Muscle diseases____

☐23. Social Diseases____

☐24. Thyroid Diseases____

☐25. Tuberculosis or Symptoms of Tuberculosis____

☐26. Other diseases not listed____

Please list any vitamins, supplements or herbal/homeopathic remedies that you are currently taking:

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

Are you allergic to any of the following:

☐ Antibiotics ☐1.Penicillin ☐2.Erythromycin ☐3.Tetracycline ☐4.Sulfa ☐5.Keflex ☐6.Clindamycin ☐7.Other______________

☐Local Anesthetics like Lidocaine or Septocaine or Carbocaine ☐Epinephrine sensitivity____________________

☐Aspirin ☐Codeine ☐Ibuprofen, Motrin, Advil ☐Aleve ☐ Narcotics________________________________

☐Latex ☐Metals of any kind____

☐Other allergies to materials or medications____

Have you ever been advised to take medication (antibiotics or other medications) before a dental appointment? Y/N (circle)
If so, please explain____

Have you ever had a skin rash or a reaction to metal jewelry? Y/N (circle) To What?______________

Do you wear contact lens? Y/N (circle) Do you bleed excessively upon injury? Y/N (circle)

Do you drink alcohol? Y/N (circle) ______daily _______weekly _______monthly _______ socially________

Do you smoke now or **have you ever** smoked? Y/N (if yes number of years) cigarettes/day___________

cigars___________ pipes__________ chewing tobacco or snuff__________________________

Women: Is there a possibility that you may be pregnant or trying to get pregnant? Y/N (circle)

If yes, how many months pregnant? _____________

Have you ever had counseling for addictions to alcohol and/or prescription medications? Y/N (circle)

____

Do you have reason to believe you are at risk for contacting infectious or sexually transmitted diseases?

Y/N (circle) If yes, please explain____

Have you been a patient in the hospital in the past two years Y/N (circle) If so, please explain_________

____

Date of last medical visit for a checkup or physical_____________

Physicians name, address and phone number:___________________________________

Are you experiencing emotional or physical stress or pressure in your work or at home? Y/N (circle)

Please explain____

Is there anything other in your medical history that we have missed? _______________________

DENTAL HISTORY

How long has it been since you were to see a dentist?____________________________

What service was rendered?____________ Were x-rays taken? Y/N (circle)_________________

When was the last time a full series of x-rays was taken of your teeth?_____________________

Have you had regular cleanings and exams? Y/N (circle)

Do you have a fear or phobia or the dentist that prevents you from visiting the dentist on a regular basis? Y/N (circle)

Would you be interested in help to deal with this fear, such as the use of Nitrous Oxide? Y/N (circle)

Have you lost teeth? Y/N (circle) Why?____

Have you had complications with extractions?______________________________________

Have you worn braces?_____ When?______ How Long?_______ Do you still wear retainers?______

Have you had treatment for periodontal disease (gum disease) or where you told you had periodontal disease?____________ Please explain and give dates____________________________________

How often do you brush your teeth? ____x/day AM___PM___ Do you floss?_____x/day

Do you use other hygiene aids?__________________

Do your gums bleed when you brush?____ or floss?_____

Do you have an unpleasant taste in your mouth?____

Are there any areas of your mouth where foods collects or wedges between your teeth?____________

Have you noticed a dry mouth? Y/N Excessive water drinking/sipping? Y/N Frequent Use of Lozengers? Y/N

Do you have clicking or popping sounds when you open or close your mouth?______ Pain?__________

Do you clench or grind your teeth either during the day or at night?_____________________________

Do you experience headaches?________ Frequency? __________When do they come?______________

Are any of your teeth sensitive?______ Sweets? ______Cold?_______ Hot?_______ Pressure?________

TREATMENT AUTHORIZATION

I consent to whatever dental procedures and anesthetics are necessary for treatment. I also understand that payment is my obligation regardless of insurance or any other third party involvement.

Signature of Patient or Guardian____Date_______________

Signature of Dentist____Date_______________