Name (print)_____

Dental Information

Do your gums bleed when you brush? Yes No
Are your teeth sensitive to..... *Heat?* Yes No *Cold?* Yes No *Pressure?* Yes No *Sweets?* Yes No
Do you grind or clench your teeth? Yes No
Do you have any fear of dental work? Yes No
Date of last dental examination?_____What was done at that time?_____

_____

How would you describe your current dental problem?_____

_____

How do you feel about the appearance of your teeth?_____

Dental Specialists seen in the past: (circle) Endodontist Oral Surgeon Periodontist Orthodontist Prosthodontist Oral Medicine

Medical Information

1. Have you been hospitalized during the past two years?..... Yes No
2. Have you been under the care of a medical doctor during the past two years?..... Yes No
   Physician's Name_____Phone No._____
   Address_____
3. Have you taken any medications or drugs during the past two years?..... Yes No
4. Are you currently taking any medications or drugs?..... Yes No
   If yes, please list:_____
5. Are you allergic or sensitive to any medications or anesthetics?..... Yes No
   If yes, please list:_____
6. Do you use tobacco? Yes No Circle all that apply: Cigarettes.....Cigars.....Pipe.....Chew
7. Indicate which of the following you have had or currently have. Circle "Yes" or "No" to each item:

Congestive Heart Failure..... Yes No	Diabetes (Type I, Type II).....Yes No	H.I.V. Positive.....Yes No
Heart Disease or Attack .....Yes No	Glaucoma.....Yes No	A.I.D.S.....Yes No
Angina Pectoris .....Yes No	Emphysema.....Yes No	Kidney Disease.....Yes No
Congenital Heart Disease.....Yes No	Chronic Cough.....Yes No	Cold Sores/Oral Herpes.....Yes No
Heart Murmur .....Yes No	Asthma.....Yes No	Blood Transfusion.....Yes No
Arteriosclerosis..... Yes No	C.O.P.D.....Yes No	Hemophilia.....Yes No
Mitral Valve Prolapse .....Yes No	Tuberculosis.....Yes No	Anemia.....Yes No
Artificial Heart Valve.....Yes No	Pneumonia.....Yes No	Sickle Cell Disease.....Yes No
Heart Pacemaker or Defibrillator.....Yes No	Other Lung Disease.....Yes No	Epilepsy or Seizures.....Yes No
High Blood Pressure.....Yes No	Hay Fever.....Yes No	Fainting or Dizzy Spells.....Yes No
Heart Surgery.....Yes No	Allergies or Hives.....Yes No	Developmentally Disabled.....Yes No
Arthritis or Rheumatoid Arthritis.....Yes No	Sinus Trouble.....Yes No	Psychiatric Disorder.....Yes No
Rheumatic Fever.....Yes No	Cancer or Tumor.....Yes No	Dementia or Alzheimer's.....Yes No
Cortisone Medicine.....Yes No	Radiation Therapy.....Yes No	Visually Impaired.....Yes No
Drug or Medication Addiction.....Yes No	Chemotherapy.....Yes No	Hearing Impaired.....Yes No
Stroke.....Yes No	Liver Disease.....Yes No	Sleep Apnea.....Yes No
Artificial Joints (hip, knee, etc.).....Yes No	Hepatitis A, B, or C.....Yes No	Latex Allergy.....Yes No
Ulcers.....Yes No	Thyroid Problems.....Yes No	Neck or Back Problems.....Yes No

8. When you climb stairs or take a walk, do you have to stop because of pain in your chest, shortness of breath, or because you are very tired?..... Yes No
9. Have you unintentionally gained or lost more than 10 pounds in the past year?..... Yes No
10. Do you ever wake up from sleep and feel short of breath?..... Yes No
11. Are you on a special diet?..... Yes No
12. Do you have, or have you had, any disease, condition, or problem not listed?..... Yes No
    If yes, please list:_____

FOR WOMEN ONLY:
Are you pregnant? Yes No If yes, what month?_____ Are you nursing? Yes No

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

Patient Signature_____Date_____

GET ACQUAINTED QUESTIONNAIRE

WELCOME TO OUR OFFICE!

By whom were you referred? _____

PATIENT INFORMATION

If patient is a child: NAME _____

☐ Dr.
☐ Mr.
☐ Mrs.
☐ Miss
☐ Ms.

CHILD'S BIRTH DATE _____

_____ _____ _____
FULL NAME OF PATIENT (IF CHILD, FATHER'S INFORMATION) **BIRTH DATE** **SOCIAL SECURITY NUMBER**

_____ _____
RESIDENCE ADDRESS **CITY & ZIP**

_____ _____ _____
E-MAIL **HOME PHONE** **CELL PHONE**

_____ _____
OCCUPATION **EMPLOYER**

_____ _____ _____
ADDRESS OF EMPLOYER **CITY, STATE, ZIP** **PHONE**

_____ _____ _____
FULL NAME OF SPOUSE (IF CHILD, MOTHER'S INFORMATION) **BIRTH DATE** **SOCIAL SECURITY NUMBER**

_____ _____
RESIDENCE ADDRESS (IF DIFFERENT FROM ABOVE) **CITY & ZIP**

_____ _____ _____
E-MAIL **HOME PHONE** **CELL PHONE**

_____ _____
OCCUPATION **EMPLOYER**

_____ _____ _____
ADDRESS OF EMPLOYER **CITY, STATE, ZIP** **PHONE**

_____
NAMES & AGES OF DEPENDENT CHILDREN

_____
NAME , ADDRESS, & PHONE NUMBER OF PERSON FINANCIALLY RESPONSIBLE (IF DIFFERENT FROM ABOVE)

_____
NAME, ADDRESS & PHONE NUMBER OF PERSON TO CONTACT IN CASE OF EMERGENCY

DENTAL INSURANCE INFORMATION

	FIRST	SECOND
NAME OF EMPLOYEE:		
RELATIONSHIP TO PATIENT		
NAME OF INSURANCE		
ADDRESS OF INSURANCE		
GROUP NUMBER		
UNION LOCAL NAME & NUMBER		

ACKNOWLEDGEMENT & AUTHORITY

I consent to treatment as necessary or desirable for the care of the above named patient. I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full. AT THE TIME OF SERVICE, unless other arrangements are made with the Financial Department. I authorize this office to make credit inquiries on my name for the purpose of obtaining credit. In the event of delinquency I agree to pay cost of collection and reasonable attorneys fees.

DATE _____ SIGNED _____
Patient, Parent or Agent (must be 18 years or older)

CONFIDENTIAL INFORMATION - IMPORTANT FOR OUR FILES & YOUR HEALTH