ACQUAINTANCE FORM

☐ Single
☐ Married
☐ Divorced
☐ Widowed

Name _____ Date of Birth _____

Address _____ Home Phone # ( ) _____

City _____ State _____ Zip _____ Work Phone # ( ) _____

Occupation _____ Social Security # _____

Employed by _____ Driver's License # _____

Address _____

How did you hear about our office? _____

Spouse's Name _____ Date of Birth _____

Address _____ Home Phone # ( ) _____

City _____ State _____ Zip _____ Work Phone # ( ) _____

Occupation _____ Social Security # _____

Employed by _____ Driver's License # _____

Address _____

Are you responsible for payment? ☐ Yes ☐ No

If **NO**, please provide us with the following information:

Name of person responsible for this account: _____ Date of Birth _____

Address _____ Home Phone # ( ) _____

City _____ State _____ Zip _____ Work Phone # ( ) _____

Occupation _____ Social Security # _____

Employed by _____ Driver's License # _____

Address _____

Do you currently have dental insurance? ☐ Yes ☐ No

If **YES**, please provide us with the following information:

Insurance Company Name _____

Subscriber's Name _____ Group # _____

Are you also covered under **ANOTHER** dental insurance? ☐ Yes ☐ No

If **YES**, please provide us with the following information:

Insurance Company Name _____

Subscriber's Name _____ Group # _____

Signature: _____ Date _____

(OVER)

MEDICAL HEALTH

General Health (please check): ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of Physician _____ Phone # ( ) _____

Address _____ City _____

Date of Last Physical _____

Do you have a history of the following:

Heart Disease	Yes☐ No☐	Shortness of Breath	Yes☐ No☐	Kidney Trouble	Yes☐ No☐
Heart Attack	Yes☐ No☐	Lung Disease	Yes☐ No☐	Venereal Disease	Yes☐ No☐
Heart Surgery	Yes☐ No☐	Tuberculosis (TB)	Yes☐ No☐	AIDS	Yes☐ No☐
Pacemaker	Yes☐ No☐	Emphysema	Yes☐ No☐	Epilepsy	Yes☐ No☐
Rheumatic Fever	Yes☐ No☐	Asthma or Hay Fever	Yes☐ No☐	Fainting/Dizzy Spells	Yes☐ No☐
Abnormal Blood Pressure	Yes☐ No☐	Sinus Trouble	Yes☐ No☐	Glaucoma	Yes☐ No☐
Heart Murmur	Yes☐ No☐	Diabetes	Yes☐ No☐	Cancer	Yes☐ No☐
Congenital Heart Lesions	Yes☐ No☐	Sickle Cell Disease	Yes☐ No☐	Radiation Treatment	Yes☐ No☐
Anemia	Yes☐ No☐	Hemophilia	Yes☐ No☐	Drug Addiction	Yes☐ No☐
Excessive Fatigue	Yes☐ No☐	Jaundice or Liver Disease	Yes☐ No☐	Alcoholism	Yes☐ No☐
Stroke	Yes☐ No☐	Hepatitis	Yes☐ No☐	Psychiatric Treatment	Yes☐ No☐
Joint Replacement	Yes☐ No☐	Intestinal Disturbances	Yes☐ No☐	Nervousness	Yes☐ No☐
Arthritis or Rheumatism	Yes☐ No☐	(ulcer, colitis, etc.)		Latex Allergy	Yes☐ No☐
				Phen Fen Use	Yes☐ No☐

_____

_____

_____

Do you have any disease, condition, or problem not listed above that you think we should know about? ☐ Yes ☐ No

If so, explain: _____

Are you now taking medications prescribed by your physician? ☐ Yes ☐ No

If so, please list the medicine and what ailment it is for: _____

_____

Has your physician ever told you to take antibiotic drugs **prior** to dental treatment? ☐ Yes ☐ No

If so, please list: _____

Have you become **sick** from, shown an **allergy** to, or been told **not to take** any medicine? ☐ Yes ☐ No

If so, please list: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No

If so, explain: _____

_____

Do you smoke or chew tobacco? ☐ Yes ☐ No If so, how much? _____

(Women): Are you pregnant? ☐ Yes ☐ No Due Date: _____

Person other than yourself who should be notified in case of an emergency _____ Phone # ( ) _____

DENTAL HEALTH

Have you ever experienced any unfavorable reaction from any dental treatment? ☐ Yes ☐ No

If so, explain _____

Have you come to this office for the relief of pain? ☐ Yes ☐ No

If yes, where is the pain? _____

How long have you had this pain? _____

Have you been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ☐ Yes ☐ No

How often do you brush your teeth? _____

What texture brush do you use? ☐ Soft ☐ Medium ☐ Hard ☐ Nylon ☐ Natural ☐ Electric

Do you use a water pik? ☐ Yes ☐ No How often? _____

How often do you floss? _____

Do your gums bleed or are they painful while flossing or brushing? ☐ Yes ☐ No

Do your gums feel tender or swollen? ☐ Yes ☐ No

Do you ever get fever blisters, cold sores, or canker sores? ☐ Yes ☐ No

Have you ever had braces to straighten your teeth? ☐ Yes ☐ No

Do you often find yourself clenching or grinding your teeth while sleeping or awake? ☐ Yes ☐ No

Do your jaws ever make noise or give you pain? ☐ Yes ☐ No

Have you ever worn dentures? ☐ Yes ☐ No

If so, for how long? _____

How many sets have you had? _____

_____

Signature _____ Date _____

_____