Acquaintance Form

It is important that we get to know about your medical and dental history. Many things have a direct bearing on your dental health. The information you give us is strictly confidential and will not be released to anyone without your permission.

Patient Information

Patient's name____ Date of birth__________________________

Address____Social Security_________________________________

Telephone: Home____________________________ Cell ________________________ Work_______________________________

Employer____ Position____

Marital status________________ Name of spouse if married____

Email____ Would you like to be notified of appointments by text ☐ email ☐

Emergency Information

In case of emergency contact____ Relationship________________________________

Phone_______________________________________ Address____

Responsible Party Information

Person responsible for payment_______________________________________ Relationship___________________________________

Address____ Phone ____

Date of birth__________________________ Social Security____

Insurance Information

Dental Insurance Company _____________________________________ Subscriber name_____________________________________

Group #_____________________________________ Insurance ID #____

If covered by dual insurance-

Secondary Insurance Company_________________________________ Subscriber name_____________________________________

Group #_____________________________________ Insurance ID #____

I understand that payment is ultimately my obligation regardless of insurance or third party involvement.

Signature of patient or guardian____ Date ______________________________

Medical History

Name and address of physician____

Date of last physical examination____

Have you ever been advised by a physician to take an antibiotic before dental treatment?___________________________________

Joint replacement?________________________________ Heart valve replacement?______________________________________

Have you been hospitalized in the last five years?____

Medications you are presently taking____

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Vitamins, herbal, or homeopathic supplements____

Allergies to medications____

Allergies to pollen, latex, metals, other____

Please check all that apply:

☐ Diabetes	☐ Arthritis	☐ Osteoporosis or Paget's	☐ Cancer	☐ Autoimmune disease
☐ Thyroid medication	☐ Neurological disorder	☐ Asthma	☐ COPD or emphysema	☐ Blood thinners
☐ Blood clots or strokes	☐ Heart disease	☐ Heart attack	☐ High or low blood pressure	☐ Sleep apnea
☐ Snoring	☐ CPAP	☐ Headaches or migraines	☐ Hormone replacement or birth control	☐ Pregnant
☐ Hepatitis	☐ Tuberculosis	☐ Venereal disease	☐ AIDS or HIV positive	☐ HPV
☐ History of substance abuse	☐ Stomach problems like GERD or ulcers	☐ Eating disorder	☐ Tobacco use	☐
☐	☐	☐		

Any medical issues not covered above?____

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Notes:____

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Dental History

How long has it been since you have seen a dentist?____

Do you have regular cleanings and exams?____

How long has it been since you have had your teeth cleaned?____

Were X-rays taken?____

Are you happy about the appearance of your smile?____

If not, what would you like to change?____

Please check all that apply:

☐ Have you been told or have been treated for periodontal disease?	☐ Did you have orthodontics?	☐ If so, do you wear retainers?	How often do you brush your teeth? ______ X day
How often do you floss your teeth? _____ X day	☐ Do you use any hygiene aids?	☐ Do your gums bleed when you floss or brush?	☐ Do you have dental implants?
☐ Do you wear dentures or partials?	☐ Have you noticed a dry mouth?	Are your teeth sensitive to: ☐ Hot ☐ Cold ☐ Sweets ☐ Biting	☐ Do you grind your teeth?
☐ Do you wear a bite guard?	Do you now or have you had TMJ problems? ☐ Clicking or popping ☐ Pain ☐ Locking ☐ Limited opening	☐ Do you have migraine headaches?	☐ Do you drink pop, sports drinks, coffee or tea with sugar?
☐ Do you wear a dental appliance for snoring or sleep apnea?	☐ Do you use tobacco products?	Have you ever had a problem with : ☐ Local anesthetics ☐ Narcotics ☐ NSAIDs (Motrin, Aleve, etc) ☐ Epinephrine ☐ Antibiotics	

Notes: ____

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