PATIENT ACQUAINTANCE FORM

Patient Name: _____ Home Phone: (_____) _____-_____

Address: STREET _____ Work Phone: (_____) _____-_____

CITY _____ STATE _____ ZIP _____ Mobile Phone: (_____) _____-_____

Sex: _____ Marital Status: _____ Birthday: _____ / _____ / _____ Social Security # _____ - _____ - _____

Patient E-Mail Address: _____ Does our office have permission to contact you via e-mail? Circle One **Yes** or **No**

Emergency Contact: _____ Primary Phone # (_____) _____-_____

Address: _____ Secondary Phone # (_____) _____-_____

Dental Insurance Co.: _____ Employer Name: _____

Employer Address: _____ Empl (H/R) Phone: (_____) _____-_____

Policyholder Relationship to Patient: _____ Policyholder Birthday: : ____ / ____ / ____ Group# _____ Social Security # _____ - _____ - _____

Secondary Insurance Co.: _____ Employer Name: _____

Employer Address: _____ Empl (H/R) Phone: (_____) _____-_____

Policyholder Relationship to Patient: _____ Policyholder Birthday: : ____ / ____ / ____ Group# _____ Social Security # _____ - _____ - _____

Name of friend or relative not living with you: _____ Home Phone: (_____) _____-_____

How did you hear about our office? _____ E-Mail Address: _____

DOES YOUR MEDICAL HISTORY INCLUDE ANY OF THE FOLLOWING CONDITIONS? – INDICATE WITH AN (X)

- ❑ Allergic to any drugs or anesthetics – Please List: _____
- ❑ Do you now have or have you been exposed to HIV / AIDS?
- ❑ Hepatitis or liver problems?
- ❑ Joint replacement (Hip, knee, etc)? When? _____
- ❑ Any heart ailments (Vascular surgery, pacemaker)?
- ❑ Mitral Valve Prolapse / Heart Murmur?
- ❑ Rheumatic Fever?
- ❑ Have you ever suffered a stroke?
- ❑ Do you have high blood pressure?
- ❑ Are you taking a blood thinner (Coumadin, Warfarin, Aspirin)?
- ❑ Excessive bleeding from a cut or a dental extraction?
- ❑ Have you ever taken Fosomax? (How long?) _____
- ❑ Do you have anemia or blood problems?
- ❑ Tuberculosis?
- ❑ Ulcer or colitis?
- ❑ Epilepsy?
- ❑ Kidney Problems?
- ❑ Diabetes?
- ❑ Do you have arthritis?
- ❑ Radiation Treatments?
- ❑ Malignancies?
- ❑ Nervous disorders, fainting, or dizziness?
- ❑ Venereal disease?
- ❑ Do you have asthma?
- ❑ Hay fever or allergies in general?
- ❑ Sinus problems?
- ❑ Are you pregnant?
- ❑ Cigarette, pipe, or cigar smoking? (How long?) _____
- ❑ Teeth sensitive to cold, heat, sweets, or pressure?
- ❑ Clenching or grinding of teeth?
- ❑ Gums bleed easily?
- ❑ Past periodontal treatment?
- ❑ Past orthodontic treatment?
- ❑ Unfavorable dental experience?

Physician's Name: _____ Date of last physical examination: _____ / _____ / _____

Are you currently under the care of a physician? If so, why? _____

What medicine, pills, or supplements are you taking now? _____

_____

Chief oral complaint: _____

Date of last dental exam: _____ / _____ / _____ X-Rays: _____ / _____ / _____ Cleaning: _____ / _____ / _____

Patient Signature: _____ Date: _____

(SIGNATURE OF PERSON AUTHORIZED TO CONSENT IF PATIENT IS UNDER 18 YEARS OF AGE)

To be filled out by Doctor ONLY

	UPTDATED:	Initial	Date
Medical / Dental History Review			

Doctor's Signature: _____ Date: _____

INFORMED CONSENT

I hereby give my consent to use local anesthetics, relaxants, anti-inflammatories, antibiotics, antihistamines, steroids, or pain medications if deemed necessary for the completion of any medical or dental treatment.

I hereby grant permission to take photographs of my mouth or head and neck to be used, without revealing my identity, for the furthering of medical and dental knowledge and education, especially for the benefit of other patients and dental professionals.

I understand that whenever a tooth is extracted, there is a possibility of infection, bone fracture, temporary paresthesia (numbness) of the lip, gum, tongue and/or facial skin. It is possible, although rare, that the paresthesia would be permanent.

I understand that root canal treatment is an attempt to retain a tooth that would otherwise require an extraction. Although root canal treatment has a high degree of success, it cannot be guaranteed. Occasionally a tooth undergoing root canal treatment may undergo acute infection and may require retreatment, surgery or (rarely) extraction. Restoration with a crown or a ceramic onlay should always follow a root canal treatment to ensure a good long term prognosis. Sometimes a post is also indicated.

I understand that preparation of teeth for crowns, bridges, fillings, and onlay/inlays may, on occasion, traumatize the pulp (nerve). If the pulp (nerve) is in a weakened condition, this may necessitate a root canal treatment on the tooth in the future.

Women taking birth control pills should be aware that antibiotics, such as penicillin or erythromycin, could possibly counteract the effects of the pill, and render it ineffective against preventing pregnancy.

I realize that any of the treatment that the doctor proposes can also be performed by a specialist. I will tell the doctor or his staff if I desire that a specialist perform the treatment.

Finally, I realize that any costs incurred during treatment are my responsibility. I realize that my insurance may help pay part of my treatment costs and that any estimates of insurance benefits quoted to me are *only* estimates. I will ultimately be responsible for any balance on my account left unpaid by the insurance company. I understand that I would be charged interest on any unpaid balance at a monthly rate of 1.5%. I also understand that if I am taken to collection, I will be responsible for any attorney fees incurred.

I understand that if I fail to give 24 hours notice to cancel a scheduled/reserved appointment time block, that I will be charged a fee up to the amount of the scheduled appointment procedure. I also understand that any X-rays taken are the property of the dentist, and that a fee may be charged for any duplication or transfer of said X-rays. I have not taken any mood or mind altering drugs prior to signing this form.

Signed _____ Date _____

Patient, Parent, or Guardian