

# 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: \_\_\_\_\_ Preferred method of contact: \_\_\_\_\_

**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 # \_\_\_\_ - \_\_\_\_ - \_\_\_\_

How did you hear about our office? \_\_\_\_\_  
 What can we do to ensure that you have an amazing patient experience with our practice? \_\_\_\_\_

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

- |  |  |
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| <ul style="list-style-type: none"> <li><input type="checkbox"/> Allergic to any drugs or anesthetics – Please List: _____</li> <li><input type="checkbox"/> Do you now have or have you been exposed to HIV / AIDS?</li> <li><input type="checkbox"/> Hepatitis or liver problems?</li> <li><input type="checkbox"/> Joint replacement (Hip, knee, etc)? When? _____</li> <li><input type="checkbox"/> Any heart ailments (Vascular surgery, pacemaker)?</li> <li><input type="checkbox"/> Mitral Valve Prolapse / Heart Murmur?</li> <li><input type="checkbox"/> Rheumatic Fever?</li> <li><input type="checkbox"/> Have you ever suffered a stroke?</li> <li><input type="checkbox"/> Do you have high blood pressure?</li> <li><input type="checkbox"/> Are you taking a blood thinner (Coumadin, Warfarin, Aspirin)?</li> <li><input type="checkbox"/> Excessive bleeding from a cut or a dental extraction?</li> <li><input type="checkbox"/> Have you ever taken Fosomax? (How long?) _____</li> <li><input type="checkbox"/> Do you have anemia or blood problems?</li> <li><input type="checkbox"/> Tuberculosis?</li> <li><input type="checkbox"/> Ulcer or colitis?</li> <li><input type="checkbox"/> Epilepsy?</li> <li><input type="checkbox"/> Kidney Problems?</li> <li><input type="checkbox"/> Diabetes?</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Do you have arthritis?</li> <li><input type="checkbox"/> Radiation Treatments?</li> <li><input type="checkbox"/> Malignancies?</li> <li><input type="checkbox"/> Nervous disorders, fainting, or dizziness?</li> <li><input type="checkbox"/> Venereal disease?</li> <li><input type="checkbox"/> Do you have asthma?</li> <li><input type="checkbox"/> Hay fever or allergies in general?</li> <li><input type="checkbox"/> Sinus problems?</li> <li><input type="checkbox"/> Are you pregnant?</li> <li><input type="checkbox"/> Cigarette, pipe, or cigar smoking? (How long?) _____</li> <li><input type="checkbox"/> Teeth sensitive to cold, heat, sweets, or pressure?</li> <li><input type="checkbox"/> Clenching or grinding of teeth?</li> <li><input type="checkbox"/> Gums bleed easily?</li> <li><input type="checkbox"/> Past periodontal treatment?</li> <li><input type="checkbox"/> Past orthodontic treatment?</li> <li><input type="checkbox"/> Unfavorable dental experience?</li> </ul> |
|--|--|

What medicine, pills, or supplements are you taking now? \_\_\_\_\_  
 \_\_\_\_\_

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

Physician's Name: \_\_\_\_\_ Date of last physical examination: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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)

<b><u>To be filled out by Doctor ONLY</u></b>	UPDATED:	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 \_\_\_\_\_  
Patient, Parent, or Guardian

Date \_\_\_\_\_