Please remember that you are totally responsible for your account, regardless of your insurance coverage.

GET ACQUAINTED QUESTIONNAIRE

This Information Is Important for Your Health Care and Will Be Kept Confidential

Purpose of Visit ____________________ If pain, where is the pain? ____________________

Duration __________ **Who may we thank for referring you to our office?** ____________________

Patient Name ____________________ Bank Reference ____________________

Marital Status ____ ☐ Male ☐ Female Birthdate __________ SS# __________ Dr. Lic.# __________ State ____ Exp ____

Phone __________ Cell __________ E-mail __________ (Mark preferred contact)

Residence Address ____________________ City __________ State ____ Zip ______

Employer's Name ____________________ Bus. Phone __________

Employer's Address ____________________

Insurance Company ____________________ Group No. ______ Policy No. ______

Spouse's Name ____________________ Bank Reference ____________________

Birthdate __________ SS# __________ Dr. Lic.# __________ State ____ Exp ____

Phone __________ Cell __________ E-mail __________ (Mark preferred contact)

Residence Address ____________________ City __________ State ____ Zip ______

Employer's Name ____________________ Bus. Phone __________

Employer's Address ____________________

Insurance Company ____________________ Group No. ______ Policy No. ______

Nearest Friend/Relative ____________________ Phone __________

Address ____________________ City __________ State ____ Zip ______

MEDICAL HISTORY

Name of Physician ____________________ City __________ Phone __________

Date of last medical exam __________ Do you have a current medical problem? ☐ YES ☐ NO

If yes, please describe ____________________

A. Have you ever had or do you have any of the following? Please check YES or NO:

Yes	No		Yes	No	
☐	☐	Hepatitis, Liver Disease, Jaundice	☐	☐	Excessive bleeding requiring treatment
☐	☐	Rheumatic Fever	☐	☐	Venereal Disease, Social Diseases
☐	☐	Diabetes? controlled how? __________	☐	☐	Lung trouble (TB, Asthma, Emphysema)
☐	☐	High Blood Pressure? controlled how? __________	☐	☐	Arthritis, sore joints
☐	☐	Heart Trouble: what kind? __________	☐	☐	Fainting Spells, Epilepsy, Convulsions
☐	☐	Heart Murmur, Mitro Valve Prolaspe	☐	☐	Headaches
☐	☐	Shortness of Breath	☐	☐	Nervous Breakdown
☐	☐	Swelling of ankles or feet	☐	☐	X-Ray, Indium or Cobalt treatments
☐	☐	Stroke? when? __________	☐	☐	Tumor or Cancer
☐	☐	Blood trouble, Anemia, Leukemia	☐	☐	Major Operation. What Kind? __________
☐	☐	Serious Accident	☐	☐	Herpes Virus
☐	☐	Human Immunodeficiency Virus (HIV)	☐	☐	Acquired Immune Deficiency Syndrome

MEDICAL HISTORY (continued)

B. Are you now:

Yes	No		Yes	No	
☐	☐	Pregnant? Due Date? ________	☐	☐	Using thyroids
☐	☐	On a prescribed diet	☐	☐	Using Hormones (incl. birth control pills)

C. Are you now taking medicines for any of the following? If so, please list:

Yes	No		Yes	No	
☐	☐	Pain	☐	☐	Headaches
☐	☐	Nerves (tranquilizers)	☐	☐	Arthritis or Rheumatisim
☐	☐	Sleeping	☐	☐	Allergy
☐	☐	Blood (thinners, liver, iron pills)	☐	☐	Using other medicine (please specify)
☐	☐	Stomach Trouble (ulcer, other)			________
☐	☐	Heart			________

D. Ever been sick from, allergic to, or told not to take any of the following? If so, please list:

Yes	No		Yes	No	
☐	☐	Antibiotics	☐	☐	Latex or Rubber
☐	☐	Codeine	☐	☐	Novocaine (or other dental anesthetic)
☐	☐	Aspirin	☐	☐	Other ________

Do you have any disease, condition, or problem you think we should know about that is not mentioned above?

If so, please explain: ________

DENTAL HISTORY

Name of previous Dentist ________

Date of last visit ________ What was done at that time? ________

Date of last full mouth set of Diagnostic X-Rays ________

Yes	No	
☐	☐	1. Are you dissatisfied with your teeth and their appearance? If Yes, what concerns you the most? ________ If you could, what would you change? ________
☐	☐	2. Do you have any missing teeth? If Yes, why haven't you had them replaced? ________
☐	☐	3. Are there any growths, unhealed injuries, inflamed areas, or swelling in or around your mouth?
☐	☐	4. Do you have difficulty swallowing?
☐	☐	5. Do your gums bleed when brushing your teeth?
☐	☐	6 Have you ever been told you have gum disease (pyorrhea, periodontitis)
☐	☐	7. Have you ever been treated for gum (periodontal) problems?
☐	☐	8. Do you have any unpleasant odor, or taste in your mouth or experience bad breath?
☐	☐	9. Have you ever had professional instructions on dental home care?
☐	☐	10. Does food catch between your teeth? If Yes, where? ________
☐	☐	11. Is any part of your mouth sensitive to temperature, pressure, or sweets? If Yes, which part? ________
☐	☐	12. Have you ever had orthodontic treatment?
☐	☐	13. Have you ever been treated for "bad bite"?
☐	☐	14 Does dental treatment make you apprehensive? ☐ slightly ☐ moderately ☐ extremely
☐	☐	15. Have you ever experienced any unfavorable reaction to dentistry?
☐	☐	16. Have you ever experienced the calming effects of Nitrous Oxide sedation for dental treatment?

DENTAL HISTORY (continued)

Yes	No	
☐	☐	17. Do you snore or suspect you do? Do you know it can be treated?
☐	☐	18. Do you have a clicking jaw joint or have you ever experienced an inability to move your jaw or open your mouth widely? ______________________________
☐	☐	19. Do you ever awaken with awareness of your teeth or jaw?
☐	☐	20. Do you clench or grind your teeth during the day or night?
☐	☐	21. Do you have any pain or soreness around your eyes, ears, other parts of your face, neck or shoulders?
☐	☐	22. Do you frequently have headaches, neckaches, stiff or sore neck muscles?
☐	☐	23. Has your mouth ever locked open?
☐	☐	24. Do you have extensive dental crowns and bridges?
☐	☐	25. Do you wear a removable partial denture?
☐	☐	26. Do you feel that in the past you have required a lot of dental work? If Yes, has it been to replace previous dentistry, or to repair a new decay? ☐ Replace ☐ New Decay
☐	☐	27. Do you feel that you will lose more teeth and eventually have to wear full dentures?
☐	☐	28. Do you know that preventive dental care can help eliminate the need for dentures?

All facilities and personnel of this office are expressly here to serve you and your health; therefore, we ask you to advise us of any change in your medical history, insurance information or mailing address and phone number.

Please inquire about any questions which are not understood

CONSENT OF TREATMENT

I do authorize and give consent to the doctor and his staff to administer treatment, including, but not limited to, local anesthesia, analgesia and other such treatment which may be necessary for the above-named patient. I also understand that the use of these agents and some procedures embodies a certain risk. I further state that the above medical and dental history was completed fully and accurately to the best of my knowledge. **No treatment will be performed without your prior knowledge and consent. You are requested to give us 48 business hours notice to avoid a broken reserved appointment, sterilization and setup fee.**

____

Signature of Patient or Responsible Party   Date

PATIENT RESPONSIBILITY FOR FEES
AND ASSIGNMENT OF INSURANCE BENEFITS

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependent is mine. Regardless of Insurance Benefits, unless prior special arrangements are made, accounts are to be paid on date which services are provided. I herby authorize that the payment from any insurance company due may be paid directly to this office. In the event of default in payment, patient or party responsible for fees agrees to pay any and all costs of suit, collection and attorney's fees.

____

Signature of Patient or Responsible Party   Date