

Get Acquainted Questionnaire

In an effort to provide you with the finest possible service, please fill out this form as accurately and completely as you can. Some of the questions are just to get to know you a little better as **WE WELCOME YOU** to our family of outstanding patients!

PATIENT INFORMATION:

Name of Patient _____ Married Single Divorced Widowed
Address _____ Spouse (if married) _____
City _____ State ____ Zip _____
Birthdate _____ Soc Sec No _____ Driver's License _____
Phone (H) _____ Phone (W) _____ Cell _____
Who should we contact in case of emergency? _____ Phone _____
If Adult: Employed by _____ Present Position _____
How Long Held _____ Hobbies _____
If Child: School _____ Grade _____ Activities _____

Whom may we thank for referring you to our office? _____

If you have dental insurance, please fill out **Insurance Data Sheet** so we may help you file your claims.

I hereby consent to have Dr. Vitz, or any qualified Staff Member, render treatment as deemed necessary by Dr. Vitz and myself. It is my understanding that any fees incurred are MY RESPONSIBILITY. A FINANCE CHARGE of 1.5%/month applies for balances over 60 days. I will extend the courtesy of 24 – 48 hours notice if an appointment needs to be changed; otherwise, a charge of \$1.00 PER MINUTE may be assessed for BROKEN or FAILED APPOINTMENTS.

Patient's Signature

Responsible Party

Date

BILLING INFORMATION: Please fill out this section if the Responsible Party is NOT the Patient.

Responsible Party _____ Relationship to Patient _____
Address _____
City _____ State ____ Zip _____
Birthdate _____ Soc Sec No _____ Driver's License _____
Phone (H) _____ Email _____ Fax (H) _____
Phone (W) _____ Extension _____ Fax (W) _____
Employed by _____ Occupation _____
Present Position _____ How Long Held _____

John W. Vitz, D.D.S.
1844 San Miguel Drive, Suite 210
Walnut Creek, CA 94596

Medical History

Name _____ Date of Birth _____

Name of Physician _____ City _____ Phone _____

Name of Specialist _____ City _____ Phone _____

Name of person to call in case of Emergency _____ Phone _____

Date of Last Physical Examination _____ Results _____

If YES to any of these questions, please explain in detail in comment box below:

- Y N 1. Are you presently under a doctor's care?
Y N 2. Have you ever been Hospitalized or have had Major Surgery?
Y N 3. Are you taking any medications now? **(If YES, please list separately WHAT & WHY.)**
Y N 4. Have you ever been told to take ANTIBIOTICS before dental appointments?
Y N 5. Do you wear a PACEMAKER?
Y N 6. Have you ever taken the drugs **Phen-Fen** or **Redux**?
Y N 7. Are you sensitive to any Metals or Latex?
Y N 8. Do you **Smoke** and/or **Chew Tobacco**?
Y N 9. Do you use Recreational Drugs?
Y N 10. **Allergic to any Antibiotics** or to any **Anesthetics** or other Medications? **LIST THESE IN BOX BELOW**

Have you ever had in the past or have at this time, give details in box below:

High Cholesterol	Y N ?	Major Surgery	Y N ?	Tuberculosis	Y N ?
Heart Murmur	Y N ?	Rheumatic Fever	Y N ?	Venereal Disease	Y N ?
High Blood Pressure	Y N ?	Anemia	Y N ?	Diagnosed as HIV +	Y N ?
Artificial Joints	Y N ?	Leukemia	Y N ?	A.I.D.S.	Y N ?
Artificial Heart Valves	Y N ?	Excessive Bleeding	Y N ?	Drug Addiction	Y N ?
Cosmetic Surgery	Y N ?	Stomach Problems	Y N ?	Psychiatric Care	Y N ?
Pain in Chest	Y N ?	Digestive Problems	Y N ?	Thyroid Problems	Y N ?
Cold Sores/Fever Blisters	Y N ?	Kidney Problems	Y N ?	Glaucoma	Y N ?
Diabetes	Y N ?	Hepatitis A B C	Y N ?	Alcoholism	Y N ?
Asthma	Y N ?	Epilepsy or Seizures	Y N ?	Fainting Spells	Y N ?
Attention Deficit Disorder	Y N ?	Mitral Valve Prolapse	Y N ?	Anxiety Attacks	Y N ?
Chronic Cough	Y N ?	Emphysema	Y N ?	Serious Stress	Y N ?
Allergies	Y N ?	Arthritis	Y N ?	Chemotherapy	Y N ?
Hay Fever	Y N ?	Swollen Ankles	Y N ?	Radiation Therapy	Y N ?
Sinus Problems	Y N ?	Stroke	Y N ?	Steroid Treatments	Y N ?

Female Patients Only: Are you Pregnant? **Y N ?** If YES, when is your Baby's Due Date? _____
Are you Nursing? **Y N** Birth Control Pills? **Y N** Taking Hormones? **Y N**

Comments and/or Details for any "Y" Answers:

CONSENT:

I hereby authorize Dr. Vitz, or a qualified assistant, to take X-rays, study models, photographs and any other diagnostic aid deemed appropriate in order to make a thorough diagnosis my dental needs. I also authorize them to provide any treatment, medication and therapy required. I understand that the use of anesthetic agents embodies certain risks. I understand the value of an accurate Medical History and I have answered these questions truthfully.

Patient _____ Responsible Party _____ Relationship _____

Witness _____ Date _____

Insurance Data Sheet

This information is needed if you would like us to file your insurance claims on your behalf. Thank You.

INSURED PARTY - Primary:

Name _____ Relationship to Patient _____
Address _____
City _____ State _____ Zip _____
Phone (H) _____ Email _____ Cell _____
Phone (W) _____ Extension _____ Fax (W) _____
Occupation _____ How Long At Present Job _____

INSURED PARTY - Secondary:

Name _____ Relationship to Patient _____
Address _____
City _____ State _____ Zip _____
Phone (H) _____ Email _____ Cell _____
Phone (W) _____ Extension _____ Fax (W) _____
Occupation _____ How Long At Present Job _____

DENTAL INSURANCE INFO:

Primary Phone _____
Insurance Co _____
Phone Number _____
Address _____
City/State/Zip _____
Employee _____
Employer _____
Birthdate _____ Group # _____
Union or Local # _____
Emp Soc Sec # _____

Secondary Phone _____
Insurance Co _____
Phone Number _____
Address _____
City/State/Zip _____
Employee _____
Employer _____
Birthdate _____ Group # _____
Union or Local # _____
Emp Soc Sec # _____

I agree to an Assignment of Benefits which will enable any Insurance Payments to be made directly to Dr. Vitz. I realize that my insurance is a contract between me and the insurance company and that Dr. Vitz' office will do all they can to assist me in filing claims on my behalf. However, I AM SOLELY RESPONSIBLE FOR UNDERSTANDING MY INSURANCE CONTRACT and any fees incurred are MY RESPONSIBILITY. I understand that there may be a FINANCE CHARGE of 1.5% per month on balances over 60 days regardless of delays from my insurance company.

Patient's Signature

Responsible Party

Date