

GET ACQUAINTED QUESTIONNAIRE

For Office Use Only
Q / F / H

PART ONE – PATIENT INFORMATION (Please complete reverse side)

Patient Name: _____ Social Security #: _____
(Please Print) Last First Middle
Please circle one: Mr. Mrs. Ms. Miss Dr. Married / Single Sex: Male Female

Address: _____ Home Telephone: (____) _____

City: _____ State: _____ Zip: _____ Cell Phone: (____) _____

Birth Date: _____ Age: _____ Driver's License/ID #: _____ State: _____

Student? Full Time / Part Time School & Location: _____

COPY OF FULL TIME STATUS REQUIRED FOR INSURANCE BILLING

Patient's Employer: _____ Work Telephone: (____) _____

Employer's Address: _____ Occupation: _____

Referring Doctor: _____ General Dentist: _____ Email _____

PART TWO – RESPONSIBLE PARTY INFORMATION

Responsible Party: _____ Social Security #: _____
(Please Print) Last First Middle
Please Circle one: Mr. Mrs. Ms. Miss Dr. Married/Single Sex: Male Female

Relationship to Patient: Self Spouse Parent/Guardian Other: _____

Address: _____ Home Telephone: (____) _____

City: _____ State: _____ Zip: _____ Cell Phone: (____) _____

Birth Date: _____ Age: _____ Driver's License/ID #: _____ State: _____

Occupation: _____ Employer: _____

Employer's Address: _____ Work Telephone: (____) _____

PART THREE – REFERRAL/EMERGENCY INFORMATION

Whom may we thank for referring you? _____

Name of nearest friend or relative not living with you: _____

Address: _____ Relationship: _____

Home Telephone: (____) _____ Work Telephone: (____) _____ Cell Phone: (____) _____

Has Dr. Wright seen another member of your family? _____ Name / Relationship: _____

PART FOUR – INSURANCE INFORMATION

Please list your primary dental insurance coverage. We regret that our office can no longer bill dual insurance carriers.

Subscriber's Name: _____ Birth Date: _____
Last First Middle

Relationship to Patient: Self Spouse Parent/Guardian Other: _____

Home Address: _____ Telephone: (____) _____

City: _____ State: _____ Zip: _____ Cell Phone: (____) _____

Social Security #: _____ Insurance ID/Subscriber #: _____

Does your plan cover?: Dental Medical Both

Name of Insurance Carrier: _____ Group #: _____

Address: _____ Telephone: (____) _____

Subscriber's Employer: _____ Work Telephone: (____) _____

Employer's Address: _____

HEALTH HISTORY RECORD

ALL INFORMATION IS NECESSARY AND CONSIDERED HIGHLY CONFIDENTIAL

Your health is important to us. In order to provide excellent care with safety, it is necessary to become acquainted with vital information related to each patient. Thus, it is extremely important that you answer the following questions as accurately as possible. If you have any questions regarding the information requested, please feel free to ask Dr. Wright or a member of our staff.

ALLERGIES	
Penicillin _____	Codeine _____
Aspirin _____	None Known _____
Please list others _____	

Reason for current office visit: _____

A.

1. Age: _____ Height: _____ Weight: _____ Are you in good health?	YES	NO
2. Have there been any changes in your general health in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you under the care of a physician? Date of last visit: _____ If so, for what are you being treated? _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever been a patient in a hospital? Please list most recent events first	<input type="checkbox"/>	<input type="checkbox"/>
Reason: _____ Date: _____		
Reason: _____ Date: _____		
Reason: _____ Date: _____		

B.	HAVE YOU HAD, OR DO YOU CURRENTLY HAVE . . .				26	HAVE YOU HAD, OR DO YOU CURRENTLY HAVE . . .				
	Yes	No	?	Notes		Yes	No	?	Notes	
1					26					Stroke?
2					27					Thyroid trouble?
3					28					Diabetes?
4					29					Low blood sugar?
5					30					Kidney trouble?
6					31					Dialysis treatment?
7					32					Swollen ankles, arthritis or joint disease?
8					33					Stomach ulcers? Bowel problems?
9					34					Contagious diseases?
10					35					Sexually transmitted diseases?
11					36					Delayed healing?
12					37					Any reason to believe your immune system may be weakened?
13					38					A tumor or growth? Cancer?
14					39					Mental health problems?
15					40					Drug / Alcohol addiction?
16					41					Fainting spells?
17					42					Convulsions / epilepsy?
18					43					Severe headaches?
19					44					Contact lenses?
20					45					Eye diseases / glaucoma?
21					46					X-ray treatment / Chemotherapy?
22					47					Chronic fatigue / night sweats?
23					48					Pain & clicking of jaws when eating?
24					49					Malignant Hyperthermia?
25					50					Are you on a diet?

C. MEDICATIONS

Please list any kind of medicine, drug or pill that you have taken for any purpose during the recent past (up to 2 years ago):

D. FAMILY HISTORY

Is there any condition concerning your health or family's anesthetic history that the doctor should be told?	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>

E. WOMEN

1. Is there any possibility that you might be pregnant?	YES	NO
2. Estimated delivery date?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>

WOMEN - PLEASE BE ADVISED OF THE FOLLOWING:
 ANTIBIOTICS (SUCH AS PENICILLIN) MAY ALTER THE EFFECTIVENESS OF BIRTH CONTROL PILLS.
 Consult your physician/gynecologist for assistance regarding additional methods of birth control.

The above medical history is accurate and current and to the best of my knowledge.

Signature _____ Date _____
 (Parent or guardian signature, if patient is under 18 years of age)

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Comments: _____