

Form Instructions

1. Use the tab key to move from form field to form field.
2. To enter text, tab to (or click) the area you would like to type in and begin typing.
3. Some form fields require a choice to be selected. Click in the boxed or underlined area and a check mark will appear.
4. To save the form and complete at a later time, click the disc button in the adobe reader tool bar at the top left of the page.
5. To print a copy of the form for your records, click the “Print Form” button at the bottom of the last page.
6. To send the completed form to our office, click the “Submit Form” button at the bottom of the last page.

If you experience difficulty submitting this form, please follow the instruction below:

1. Print the form
2. Complete the form with a pen and bring the form to the office at the time of your appointment.
3. If you do not have a printer, you may fill out the form at our office prior to your appointment. Please allow an extra fifteen minutes before your scheduled appointment. Please call our office if you have any questions.

For your protection:

This form is hosted on a secure server and may only be viewed by our office. You may feel confident in filling out this form, as all of your information will be kept safe and confidential during the process.

Get Acquainted Questionnaire

Gerald W. Bird, D.M.D.

Board Certified in Oral and Maxillofacial Surgery

Jay A. Johnson D.M.D.

Patient Information Please Print

Today's Date: / /

Title: Mr. Mrs. Miss Ms. Mstr. Dr. Fr. Sr. Social Security Number: _____

Name: _____

Occupation: _____

Last, First Middle Initial

Street Address: _____

Employer: _____

City: _____ State: _____

Address: _____

Zip: _____ Telephone: _____

City: _____ State: _____

Daytime Telephone: _____

Zip: _____ Telephone: _____

Date of Birth: ____/____/____

Student Status: Full-Time [] Part-Time []

School Name: _____

Marital Status: Single Married Divorced Widowed

Emergency Contact: _____

Spouse: _____

Relationship: _____ Telephone: _____

Person Responsible for Payment If Not The Person Listed Above (Parent When Applicable)

Name: _____

Social Security Number: _____

Relationship To Patient: _____

Employer: _____

Street Address: _____

Address: _____

City: _____ State: _____

City: _____ State: _____

Zip: _____ Telephone: _____

Zip: _____ Telephone: _____

Referral Information Whom May We Thank For Referring You? _____

Name of Dentist: _____

Did you bring x-rays with you? Yes [] No []

City: _____ Date of Last Visit: _____

Name of Physician: _____

Other Dental Specialist(s): _____
(i.e. Orthodontist, Periodontist)

City: _____ Date of Last Visit: _____

Insurance Information Do You Desire To File A Claim? Yes [] No [] Dental [] Medical [] Both []

Name of Insured: _____

Dental Insurance Agency: _____

Relationship to Patient: _____

Address: _____

Social Security Number: _____

Medical Insurance Company: _____

Insured's Date Of Birth: _____

Address: _____

Health History Record

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 the Doctor or a member of the staff for assistance.

Present complaint or problem and its duration _____

Allergies	
Penicillin _____	Codeine _____
Aspirin _____	Other _____
None Known _____	

Age: _____ Weight: _____ Height: _____

	Yes	No	?
1. Are you now in good health?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you now, or have you been under the care of a physician during the past 2 years?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If so, for what condition? _____			
3. Date of last physical examination: _____			
4. Have you ever been a patient in a hospital?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reason: _____			
Reason: _____			
Reason: _____			
Reason: _____			
5. Please list all medications you are currently taking or have taken in the last year. If none, write none			

A. Have you ever taken "Blood Thinners" or Steroid (Cortisone) Therapy?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Are you sensitive or allergic to penicillin or any other drugs, medicines or anesthetics?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. If so, Please list: _____			

6. Do you have, or have you ever had?: (Check all that Apply)

- | | | | |
|-------------------------------|-------------------------------------|-------------------------------------------------------|------------------------------|
| a) heart trouble | j) emphysema | s) sinus trouble | aa) venereal disease |
| b) high or low blood pressure | k) persistent cough | t) nosebleeds (frequent) | bb) drug addiction |
| c) hear murmur | l) asthma/bronchitis | u) epilepsy | cc) alcoholism |
| d) stroke | m) blood disorder/bleeding problems | V) stomach (ulcer, etc.)/ bowel problems | dd) tuberculosis |
| e) rheumatic fever | n) anemia | w) hyperthyroidism / hypothyroidism (thyroid trouble) | ee) arthritis |
| f) angina pectoris | o) porphyria | x) glaucoma | ff) scarlet fever |
| g) chest pain | p) kidney, liver or lung disease | y) cancer | gg) allergies |
| h) swollen ankles | q) hepatitis / jaundice | z) diabetes | hh) others (please indicate) |
| i) shortness of breath | r) severe headaches | | |

	Yes	No	?
7. Are you subject to any nervous disorders, fainting or dizziness?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Are you subject to excessive bleeding?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever had psychiatric treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have any difficulty in opening your mouth wide? Jaws ever click or catch?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever had any Orthodontic care?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever had any injury to your face or jaws?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever had any difficulty with past dental treatment? Explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever had a local anesthetic (numbing an area)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever had any difficulty with the use of a local anesthetic ("Novocain")?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever had a general anesthetic (completely asleep)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you or any family member experienced any problem associated with a general anesthetic or "Twilight Sleep"? Explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you have any numbness or tingling sensation in any part of your body?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you ever received radiation or surgical treatment for a tumor, growth or condition about your head, mouth, lips?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Females: Are you pregnant? _____ How many months? _____ Are you nursing a baby? _____			
21. Do you use tobacco or smoke? _____ How much? _____ How long? _____			
22. Do you wear contact lenses?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Have you had anything to eat or drink in the last 6 hours?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Is there any information, not given about, that you think is important for proper health care treatment in your case? _____			

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

Signature: _____

Date: _____