

## ACQUAINTANCE FORM AND HEALTH QUESTIONNAIRE

### WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.. We look forward to working with you in maintaining your dental health.

#### GENERAL INFORMATION

E-mail Address \_\_\_\_\_

( ) Dr. ( ) Mr. ( ) Mrs. ( ) Ms. \_\_\_\_\_ Birth Date \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Number Street City/State Zip

Home Telephone # \_\_\_\_\_

Cell Telephone # \_\_\_\_\_

Work Telephone # \_\_\_\_\_

Occupation \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Business Address \_\_\_\_\_  
Number/Street City/State Zip

Marital Status \_\_\_\_\_ Name of Spouse \_\_\_\_\_

Spouse's Occupation \_\_\_\_\_

If patient is a minor, who is legally responsible for treatment and payment? \_\_\_\_\_

Relationship \_\_\_\_\_

Number/Street \_\_\_\_\_

City/State \_\_\_\_\_

Zip \_\_\_\_\_

Telephone # \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

In case of emergency who should be notified? \_\_\_\_\_ Phone # \_\_\_\_\_

#### DENTAL INSURANCE INFORMATION

Name of **Dental** Insurance Carrier: \_\_\_\_\_ Agreement #: \_\_\_\_\_

Name of Group Dental Plan: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Subscriber's Social Security # \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_ Address \_\_\_\_\_ Telephone # \_\_\_\_\_

Subscriber's Birth Date: \_\_\_\_\_

Has the patient had previous dental care under this plan? \_\_\_\_\_ Patient's Relationship to Subscriber: \_\_\_\_\_

Is the patient covered by another Dental plan? \_\_\_\_\_ If so, name of plan \_\_\_\_\_ Group # \_\_\_\_\_

Does patient have **medical** insurance? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Agreement # \_\_\_\_\_

#### MEDICAL/HEALTH HISTORY

Family Physician \_\_\_\_\_ Specialty: \_\_\_\_\_

Address \_\_\_\_\_ Telephone #: \_\_\_\_\_

Additional Physician \_\_\_\_\_ Specialty: \_\_\_\_\_

Address \_\_\_\_\_ Telephone #: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Age: \_\_\_\_\_ Date of Last medical examination: \_\_\_\_\_

Yes No Have you been a patient in the hospital during the past two years? \_\_\_\_\_

Yes No Have you been under the care of a medical doctor during the past two years? \_\_\_\_\_

Yes No Have you ever had any excessive bleeding requiring special treatment? \_\_\_\_\_

Yes No Are you allergic (i.e. itching, rash, swelling of hands, feet or eyes) or made sick by any drug or medication? If yes, please list: \_\_\_\_\_

Yes No Have you taken any medicine or drugs during the past two years? \_\_\_\_\_  
For what? \_\_\_\_\_

Yes No Are you allergic to latex rubber? Yes No Are you taking Coumadin?

Please list medications currently taking (include over the counter drugs, herbal medicines and dietary supplements): \_\_\_\_\_

**Circle any of the following which you have had or have at present:**

- |  |                           |                                |
|--|---------------------------|--------------------------------|
| Heart Murmur                           | AIDS/HIV Positive         | Arthritis                      |
| Mitral Valve Prolapse                  | Genital Herpes            | Artificial Joints              |
| Heart Surgery                          | Venereal Disease          | Rheumatism                     |
| Heart Failure                          | Cold Sores                | Circulatory Problems           |
| Heart Disease or Attack                | Blood Transfusion         | Allergies or Hives             |
| Heart Pacemaker                        | Hepatitis A (Infectious)  | Fainting/Dizzy Spells          |
| Coronary Occlusion                     | Hepatitis B               | Hay Fever                      |
| Congenital Heart Lesions               | Hepatitis C               | Sinus Trouble                  |
| Rheumatic Fever                        | Hemophilia                | Asthma                         |
| Scarlet Fever                          | Bruise Easily             | Persistent Cough               |
| Stroke                                 | Sickle Cell Disease       | Respiratory Disease            |
| Artificial Heart Valve                 | Anemia                    | Kidney Trouble                 |
| Arteriosclerosis                       | Blood Disease             | Liver Disease                  |
| Angina Pectoris                        | Alcoholism                | Glaucoma                       |
| High Blood Pressure                    | Drug/Chemical Dependency  | Emphysema                      |
| Low Blood Pressure                     | Cancer                    | Epilepsy/Seizures              |
| Heart Problems                         | Describe _____            | Diabetes                       |
| Describe _____                         | Chemotherapy              | Tuberculosis (TB)              |
| Insomnia                               | X-ray or Cobalt Treatment | Contact Lenses                 |
| Ulcers                                 | Thyroid Disease           | Pain in Jaw Joints (TMJ)       |
| Tonsillitis                            | Numbness                  | Tobacco Habit                  |
| GERD (gastroesophageal reflux disease) |                           | <b>None of the above</b> _____ |

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath or because you are very tired? ..... Yes No

Do your ankles swell during the day? ..... Yes No

Do you use more than 2 pillows to sleep? ..... Yes No

Have you lost or gained more than 10 pounds in the past year? ..... Yes No

Do you ever wake up from sleep short of breath? ..... Yes No

Are you on a special diet? ..... Yes No

Has your medical doctor ever said you have cancer or a tumor? ..... Yes No

Do you have any disease, condition or problem not listed? ..... Yes No

Have you ever been involved in a serious accident? ..... Yes No

Do you take more than one alcoholic drink a day? \_\_\_\_\_ How many? \_\_\_\_\_

Do you use any tobacco products? \_\_\_\_\_ Which type? \_\_\_\_\_ How much? \_\_\_\_\_ How Long? \_\_\_\_\_

**Women:** Are you pregnant now? ..... Yes No

Do you take birth control medication? ..... Yes No

Have you reached menopause? ..... Yes No

If so, are you taking supportive medication ..... Yes No

**DENTAL HISTORY**

**What is your immediate dental concern?** \_\_\_\_\_

Primary Dentist: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Period of treatment: \_\_\_\_\_ (Date)

Specialty Dentist: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Date of last dental visit: \_\_\_\_\_ Date of last dental x-rays: \_\_\_\_\_

**Please circle YES or NO. If YES, please fill in details.**

Yes No Are you presently in any pain? \_\_\_\_\_

Yes No Have you ever experienced any unfavorable reaction to dentistry? \_\_\_\_\_

Yes No Have you ever had orthodontic treatment? \_\_\_\_\_ When? \_\_\_\_\_

Yes No Do you have any growths or swellings in your mouth? \_\_\_\_\_  
How long have they existed? \_\_\_\_\_

Yes No Do you have any difficulty in swallowing? \_\_\_\_\_

Yes No Have you ever been told you have gum disease? \_\_\_\_\_ When? \_\_\_\_\_

Yes No Have you ever had a bad reaction to a dental anesthetic? \_\_\_\_\_ Describe: \_\_\_\_\_

Yes No Do you have any pain or soreness around your eyes or ears or other parts of your face? \_\_\_\_\_

Yes No Are you aware of stiff neck muscles? \_\_\_\_\_ How Often? \_\_\_\_\_

Yes No Do you ever awaken with an awareness of your teeth or jaw? \_\_\_\_\_ How Often? \_\_\_\_\_

Yes No Are you aware of clenching your teeth during your daytime hours? \_\_\_\_\_ How Often? \_\_\_\_\_

Yes No Have you ever been told you grind your teeth during sleep? \_\_\_\_\_ How Often? \_\_\_\_\_

Yes No Are you aware of your jaw clicking or popping while eating or yawning? \_\_\_\_\_ How Often? \_\_\_\_\_

Yes No Do you have difficulty in opening your mouth widely? \_\_\_\_\_

Yes No Do you have "tension" headaches? \_\_\_\_\_ How Often? \_\_\_\_\_

Yes No Are you dissatisfied with your teeth and their appearance? \_\_\_\_\_

Yes No Do you feel you will eventually wear full dentures? \_\_\_\_\_

Yes No If you have dental disease, do you think it is active? \_\_\_\_\_

Yes No Do you have any disease, condition, or problem not listed that you think we should know about?  
If so, explain: \_\_\_\_\_

Yes No Do you feel very nervous about having dental treatment? If so, explain: \_\_\_\_\_

Yes No Do you or your spouse have a history of periodontal disease? If so, explain: \_\_\_\_\_

**FINANCIAL POLICY STATEMENT**

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. Charges not paid within 30 days of receipt of this statement are subject to a "Late Charge" of 1-1/4% per month (15% annual rate). Minimum "Late Charge" fee is \$.50.

If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred in collecting your account.

**AUTHORIZATION**

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and understand it is my responsibility to inform this office of any changes to the information I have provided.

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

**I fully understand I am solely responsible for all charges whether or not paid by insurance and agree to the financial policy.**

Patient's Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

If you are completing this form for another person, what is your relationship to that person? \_\_\_\_\_