PATIENT AQUAINTANCE RECORD

Date:__________ Birthdate:__________ Married________ Single________

Patient's Full Name:__________ Social Security Number:__________

If the patient is a minor: Drivers License State & Number:__________

Guardians Full Name:__________ Guardians Social Security #:__________

Patients Address:__________ City:__________

State:______ Zip Code:______ Telephone Number:__________

Mr. Employer:__________ Business Address:__________

City:______ State:______ Zip Code:______ Phone:______

Occupation:__________ Schedule:__________

Ms. Employer:__________ Business Address:__________

City:______ State:______ Zip Code:______ Phone:______

Occupation:__________ Schedule:__________

Dental Insurance: YES or NO Name of Insurance and Main Subscriber:__________

In case of an emergency, name a relative not living with you:__________

Relationship:__________ Phone Number:__________

DENTAL HEALTH

When was you last dental visit:__________ Purpose of call:__________

How often do you brush:__________ How often do you floss:__________

Do your gums bleed while brushing:__ flossing:___ Do you avoid brushing any part of your mouth due to pain:__

If YES, what part:________ Have you had any serious complications associated with dental treatment:__

If YES, please explain:__________

Do you feel twinges of pain when your teeth come in contact with: Sweets:______ Sours:______

Hot Foods or Liquids:____ Cold Foods or Liquids:____ Do your gums feel tender or swollen:______

Do you wear dentures:______ Do you gag easily:______

Have you ever had any reaction to anesthetic:______ if yes, explain:__________

MEDICAL HEALTH

Is your health: Excellent:______ Good:______ Fair:______ Poor:______

Under a Physicians Care:_____ Whom:__________

Medications:__________

If so, what are they used for:__________

ARE YOU ALLERGIC TO: Penicillin______ Codeine______ Sulfur______
Other__________

Does YOUR medical history include any of the following conditions: (please circle)

Heart Disease Heart Murmur Abnormal Blood Pressure Congenital Heart Lesions Diabetes
Hepatitus Anemia Ulcers Tuberculosis Sinus Trouble Ear Trouble Arthritus
Epilepsy Jaundice Cough Stroke Rheumatic Fever Glaucoma Thyroid Condition
Frequent or Severe Headaches Asthma Hay Fever

Have you ever been tested for AIDS:______ If so, when:__________ Positive or Negative

Have you ever been treated with radiation:_____ Reason:__________

Are you subject to prolonged bleeding:______ Are you subject to Fainting Spells:______

Is there any chance you could be pregnant:____ If so, how far along:__________

Do you have excessive Thirst or Urination:____ Have you ever taken steroids:____ why:______

Please add anything you feel is important:__________

I hereby authorize my insurance carrier to reimburse the dentist directly for all dental services performed. I also understand that I will be responsible for any services not paid for by my insurance company.

____________________ __________

Signature Date