Getting Acquainted

Patient Information

Name _____ Home Phone _____

Address _____ City _____ Zip _____

Employer _____ Business Phone _____

Business Address _____ City _____ Zip _____

Birthdate _____ Hobbies _____

Social Security # _____ School _____

Medical History (Please check any past or present conditions)

	Yes	No		Yes	No
Rheumatic fever	❑	❑	Do you take vitamins or dietary supplements.	❑	❑
Heart problems	❑	❑	Experience loss of consciousness	❑	❑
High blood pressure	❑	❑	Allergic to latex	❑	❑
Heart murmur	❑	❑	Allergic to penicillin	❑	❑
Anemia	❑	❑	Allergic to any medication	❑	❑
Blood disease	❑	❑	Allergic to local anesthesia	❑	❑
Diabetes	❑	❑	Abnormal bleeding from a cut	❑	❑
Are you pregnant	❑	❑	Hepatitis	❑	❑
Joint replacement or implants	❑	❑	Venereal disease	❑	❑
Do you use tobacco products	❑	❑	AIDS / HIV+	❑	❑

DATE	INITIAL	NOTES

Any medical problems not covered above? _____

Are you now taking any medicines (including non-prescription)? _____

Physician's Name _____ Phone _____

Purpose of this visit? _____

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

Person to call in case of emergency _____ Phone _____

Responsible Party Information

Name _____ Home Phone _____

Address _____ City _____ Zip _____

Employer _____ Business Phone _____

Business Address _____ City _____ Zip _____

Relationship to patient _____

Spouse Information

Name _____ Home Phone _____

Address _____ City _____ Zip _____

Employer _____ Business Phone _____

Business Address _____ City _____ Zip _____

Insurance Information for Head of Household

Name of insured _____ SS# of insured _____ Date of birth _____

Name of insurance company _____ Policy# _____

Secondary Insurance Information

Name of insured _____ SS# of insured _____ Date of birth _____

Name of insurance company _____ Policy# _____

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable, including the use of local anesthesia and other medication as indicated. I understand that I am fully responsible for all charges incurred for dental treatment and consultation, irrespective of any insurance coverage I may have.

_____ _____

Signature of Patient, Parent or Guardian Date