

CONFIDENTIAL PATIENT INFORMATION

GET AQUAINTED QUESTIONNAIRE

Welcome to our office. We feel you will be pleased with the care you will be receiving. In order to begin treatment, the following information is necessary. Please complete fully and PRINT legibly. All information, of course, will be held in strict confidence. Thank you for joining our family of patients.

PATIENT HISTORY INFORMATION

PATIENT'S NAME _____ HOME PHONE _____
SOC. SEC. # _____ BIRTHDATE _____ AGE _____ SEX _____ MARITAL STATUS _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PATIENTS EMPLOYER _____ WK PHONE _____
SPOUSE'S NAME _____ SPOUSE'S EMPLOYER _____
PERSON TO NOTIFY IN CASE OF EMERGENCY _____ PHONE _____
RELATIVE OR FRIEND NOT LIVING WITH YOU _____ PHONE _____
STUDENT: FULLTIME PART TIME SCHOOL _____ CITY _____

FAMILY MEMBERS	AGE	LAST VISIT TO THE DENTIST
SPOUSE		
CHILD		
CHILD		
CHILD		
CHILD		

RESPONSIBLE PARTY'S INFORMATION

PERSON RESPONSIBLE FOR THE ACCOUNT _____

RELATIONSHIP to PATIENT _____	HOME PHONE _____	WK PHONE _____
MAILING ADDRESS _____	CITY _____	ZIP _____
SOC. SEC# _____	DRIVER'S LICENSE # _____	
EMPLOYER _____	OCCUPATION _____	
EMPLOYER'S ADDRESS _____	CITY _____	ZIP _____
DENTAL INSURANCE <input type="checkbox"/> YES <input type="checkbox"/> NO	SECONDARY INSURANCE <input type="checkbox"/> YES <input type="checkbox"/> NO	
INSURED'S NAME _____	INSURED'S NAME _____	
SS# _____ BIRTHDAY _____	SS# _____ BIRTHDAY _____	
EMPLOYER _____	EMPLOYER _____	
INS. CO. OR PLAN _____	INS. CO. OR PLAN _____	
UNION/GRP. NAME _____	UNION/GRP. NAME _____	
GROUP/POLICY# _____ LOCAL # _____	GROUP/POLICY# _____ LOCAL # _____	
DATE EMPLOYED _____	DATE EMPLOYED _____	

How did you hear about the office? Patient Name of Referring PT.? _____
 Ins/Union Telephone Book TV Radio Passing by/saw sign
Why are you here today? Check-up Toothache Caps Improve Smile Other _____

CONSENT TO FINANCIAL RESPONSIBILITY

This is to certify that I, the undersigned, consent to the performing of whatever dental services and/or surgical procedures may be decided upon to be necessary or advisable, and to the use of local or general anesthetic as may be deemed advisable by the dentist. I have also been explained the consequences of partial and/or no treatment. I hereby authorize my dentist to release any and all medical information (including dental information) to the above-named insurance carrier for purpose of claims administration or evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing. I hereby authorize my Insurance Carrier to pay directly to the within named dentist(s) the dental benefits otherwise payable to me. I understand if my insurance company does not pay in full, I am responsible for the remaining balance. I understand some dental services I receive may require a co-payment from me. The amount of the co-payment will vary according to the insurance/dental plan I have and the procedure that is performed. If my insurance/dental plan has a yearly deductible, I understand it must be satisfied before treatment begins. I also understand co-payments must be paid in full at the time of treatment. A finance charge of 1.5% per month (18% per annum) will be charged on the unpaid principal balance on all accounts not paid within 30 days of the date of service. I further understand dental services not covered by my insurance/dental plan may be prescribed in certain cases by the attending dentists. Usual, customary and reasonable fees will be charged for such services. I also understand there will be a charge for any missed appointment which is not canceled 24 hours in advance.

Patient Signature

DATE

Responsible Party Signature

DATE

	Blood Pressure	Date	Insurance			HEALTH QUESTIONNAIRE		
Year 1								
Year 2			Name			Date of Birth	Acct #	
Year 3								

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental concern, but they are all associated with proper oral health care. Please answer each question and mark YES or NO as appropriate.

MEDICAL HISTORY

- | | | | | | |
|--|---|--|---|--|--------------------------|
| | YES | NO | | | |
| 1. Are you in good health? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 2. Are you now under the care of a physician?..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| If so, what is the condition being treated? _____ | | | | | |
| Physician name / phone # / Address _____ | | | | | |
| 3. Have you ever had any serious illness or operation? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| If so, what illness or operation? _____ | | | | | |
| 4. Have you ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| If so, what was the problem? _____ | | | | | |
| 5. Are you taking medicine? <input type="checkbox"/> YES <input type="checkbox"/> NO or any recreational drugs (marijuana, cocaine, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| If so, what? _____ What dosage? _____ | | | | | |
| 6. Are you sensitive or allergic to any drugs? <input type="checkbox"/> Penicillin <input type="checkbox"/> Tetracycline <input type="checkbox"/> Sulfa Drugs <input type="checkbox"/> Aspirin <input type="checkbox"/> Codeine <input type="checkbox"/> OTHER | | | | | |
| OTHER - If other, what drug(s)? _____ | | | | | |
| 7. Do you have, or have you had, any of the following: | | | | | |
| YES NO | YES NO | YES NO | YES NO | YES NO | |
| <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Liver Disease | |
| <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> <input type="checkbox"/> Heart Ailments/Attacks | <input type="checkbox"/> <input type="checkbox"/> Ulcers | <input type="checkbox"/> <input type="checkbox"/> Sinus Trouble | |
| <input type="checkbox"/> <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> <input type="checkbox"/> Hepatitis or Jaundice | <input type="checkbox"/> <input type="checkbox"/> Glaucoma | <input type="checkbox"/> <input type="checkbox"/> Blood Disease | |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> <input type="checkbox"/> Fainting Spells or Seizures | <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Drug Addiction | |
| <input type="checkbox"/> <input type="checkbox"/> Tuberculosis (T.B.) | <input type="checkbox"/> <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> <input type="checkbox"/> Chemotherapy (Cancer,Leukemia) | <input type="checkbox"/> <input type="checkbox"/> Emphysema | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> <input type="checkbox"/> Venereal Disease (Syphilis, Gonorrhea) | <input type="checkbox"/> <input type="checkbox"/> Cold Sores | <input type="checkbox"/> <input type="checkbox"/> H.I.V./ AIDS | |
| <input type="checkbox"/> <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> <input type="checkbox"/> Artificial Prosthesis | <input type="checkbox"/> <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> <input type="checkbox"/> Head Injuries | <input type="checkbox"/> <input type="checkbox"/> Hemophilia | |
| <input type="checkbox"/> <input type="checkbox"/> Tumors or Growths | <input type="checkbox"/> <input type="checkbox"/> Psychiatric Treatment | <input type="checkbox"/> <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> <input type="checkbox"/> Cerebral Palsv | <input type="checkbox"/> <input type="checkbox"/> Heart Surgerv (Valve Replacement) | <input type="checkbox"/> <input type="checkbox"/> Prosthetic Joints | | |
| | | | | YES | NO |
| 8. Do you have any disease, condition, or problem not listed that you think we should know about? | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| If so what? _____ | | | | | |
| 9. Do you smoke? If yes, how much per day? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Are you currently taking, or have you ever taken the drug Phen-Phen?..... | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. (Women) Is there a possibility you may be pregnant?..... | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. (Women) Do you have any problems associated with your menstrual period?..... | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. (Women) Do you take birth control pills?..... | | | | <input type="checkbox"/> | <input type="checkbox"/> |

DENTAL HISTORY

- | | | |
|---|--------------------------|--------------------------|
| 1. Have you ever had a local anesthetic (Novocaine, etc.)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had any unfavorable reaction from a local anesthetic?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you had any serious trouble associated with any previous dental treatment?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, explain _____ | | |
| 4. How long since your last full mouth x-rays? _____ | | |
| 5. How long since your last dental treatment? _____ | | |
| 6. Is any current dental problem the result of an accident? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, When? _____ | | |
| 7. Does dental treatment make you nervous? <input type="checkbox"/> No <input type="checkbox"/> Slightly <input type="checkbox"/> Moderately <input type="checkbox"/> Extremely | | |

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or my medications change, I will, without fail, inform the doctor at my next appointment.

Patient Signature: _____	Date: _____	DDS Signature: _____	Date: _____
Year 2 Change in Health: _____	<input type="checkbox"/> None		
Patient Signature: _____	Date: _____	DDS Signature: _____	Date: _____
Year 3 Change in Health: _____	<input type="checkbox"/> None		
Patient Signature: _____	Date: _____	DDS Signature: _____	Date: _____

DDS NOTES
