DATE:_____

PATIENT ACQUAINTANCE FORM/HEALTH QUESTIONAIRE:

Name:_____ Preferred Name:_____
Address:_____City:_____State:___Zip:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____
E-mail address:_____ Best time to Call:_____
Sex(M/F):_____Marital Status:_____
Birth date: _____ Social Security #:_____
Name of Responsible Party_____
Billing Address:_____
Policy Holder's Employer:_____
Dental Insurance Coverage: (circle) Yes No
Policy Holder:_____ Date of Birth:_____ SS#:_____
Insurance Company:_____ Group #:_____
Address:_____ Phone #:_____

How did you hear about our office?_____

Medical History:

YES	**NO**	**CHECK YES OR NO TO THE FOLLOWING QUESTIONS:**
___	___	Are you currently under the care of a physician?
___	___	Are you allergic to any medications? If you answered yes to this question, please List them here:_____
___	___	Are you taking any type of blood thinner or anticoagulant? (ie: aspirin regularly, warfarin, coumadin, plavix, clopidogrel) If you answered yes to this question, Please list here:_____
___	___	Do you have allergies, other than from medications? If yes, what: _____
___	___	Are you taking any medications? (Please list on medications page)
___	___	Are you pregnant or trying to become pregnant?
___	___	Do you have a Heart condition of any kind? Or, had heart surgery?
___	___	Have you ever had Rheumatic Fever which caused heart damage?
___	___	Do you have any artificial heart valves or blood vessels?
___	___	Have you had bacterial endocarditis?
___	___	Do you have a congenital heart disease? If yes, please specify_____
___	___	Have you had a cardiac/heart transplant?
___	___	Do you have any artificial joints?(examples: hip/knee/shoulder, etc.) Please list with date placed_____
___	___	Do you have high blood pressure?
___	___	Have you ever had a stroke?
___	___	Do you have episodes of angina? (chest pain due to exercise/physical activity)
___	___	Do you have shortness of breath during normal physical activity?
___	___	Do you have diabetes? If yes, Type 1 or Type 2:_____

___ ___ Have you ever had a venereal disease?
___ ___ Are you HIV positive, or do you have AIDS?
___ ___ Have you ever had convulsions, seizures or epilepsy?
___ ___ Have you had any respiratory disease or breathing problems?
___ ___ Do you have Tuberculosis?
___ ___ Have you ever had any abnormal bleeding problems?
___ ___ Have you ever had a blood transfusion?
___ ___ Have you ever had kidney dialysis or kidney problems?
___ ___ Have you ever had any liver problems?
___ ___ Have you ever had hepatitis or yellow jaundice?
___ ___ Do you have hemophilia or any blood disorder?
___ ___ Do you smoke?
___ ___ Do you use smokeless tobacco?
___ ___ Have you ever been on any Osteoporosis medications known as Bisphosphonates (Examples include: Fosamax, Boniva or Actonel)? If yes, please list_____
_____
___ ___ Have you ever taken any Antiresorptive drugs? (Examples include: Prolia, Xgeva and Denosumab)_____
___ ___ Have you ever taken any Antiangiogenic drugs?
___ ___ Have you been diagnosed with Myasthenia Gravis?
___ ___ Have you been diagnosed with Glaucoma? If yes, Open___ Closed____?
___ ___ **Are there any other conditions that you feel the Doctor should be aware of?**
_____

Dental History:

___ ___ Have you ever had surgery or radiation treatment in/out of your mouth?
___ ___ Have you ever had an injury to your face and/or jaw?
___ ___ Do you have frequent or severe headaches?
___ ___ Do you have any hearing loss, ear aches, or pain in/near your ears?
___ ___ Do you have frequent colds or sore throats?
___ ___ Do you have sensitive teeth?
___ ___ Have you had a toothache lately?
___ ___ Do you have bleeding gums while brushing or flossing?
___ ___ Is it difficult to open your mouth as wide as you would like?
___ ___ Does your jaw click when you open or chew?
___ ___ Do you think your teeth are affecting your general health?
___ ___ Are you worried about receiving dental treatment?
___ ___ ARE YOU DISSATISFIED WITH THE APPEARANCE OF YOUR TEETH?
___ ___ **IS THERE ANYTHING ELSE THAT YOU FEEL THE DOCTOR SHOULD KNOW ABOUT YOUR ORAL HEALTH OR ANY DENTAL CONCERNS?_____**
_____

Whom do we notify in case of an emergency?_____Phone:_____
Who is your primary care physician?_____Phone:_____
What clinic is your physician affiliated with?_____
Are there any other doctors (specialists) that you are seeing, and why?_____

General Consent to Treatment:
I understand that dentistry is not an exact science, and therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental work I have requested and authorized. I understand that despite my dentist's best efforts, sometimes unforeseeable circumstances may occur during treatment. I understand that dental treatment and the administration of anesthesia may pose certain inherent risks and side effects, including but not limited to, adverse drug responses or allergic reactions, bruising, swelling, muscle soreness, heart irregularities, dizziness and nausea, temporary or permanent numbness or change in sensation of the lip, chin, gums and tongue.

I understand the importance of providing accurate information on this form. To the best of my knowledge, all the information I have provided on this form is accurate.

I understand that payment is due at time of service. I hereby authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to be responsible for payment for all services rendered by my dentist. I understand that regardless of any insurance coverage I may have, I am responsible for payment for the dental care I receive and I will pay any fees incurred to satisfy this obligation. A service charge of 1% per month(18% per annum) on unpaid balance will be charged on all overdue accounts, unless previously written financial arrangements are satisfied.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

SIGNATURE:_____