PATIENT ACQUAINTANCE FORM

Name ______________________ Address ______________________

City ______________ State _____ Zip _______ Home Phone (   ) ______________

Work Phone (   ) ______________ Cell # (   ) ______________ Sex (M/F) _____ Marital Status ________

Birthdate ____________ Soc. Sec. # ______________ Drivers License # ______________

Person Financially Responsible ______________________ Soc. Sec. # ______________

Relationship to You ______________________ Billing Address ______________________

City ______________ State _____ Zip _______ Home Phone (   ) ______________

Employer ______________________ Work Address ______________________

Dental Insurance ______________________ Group/Plan # ______________

Spouse Name ______________________ Employer ______________________

Dental Insurance ______________________ Group/Plan # ______________

Soc. Sec. # ______________ Birthdate ______________________

Covered Dependents ____

If both you and your spouse have insurance coverage please indicate which insurance is the primary carrier. ______________

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Who referred you to our office? ____

In case of emergency, please notify ______________________ Phone No. ______________

I certify that the above information is true and complete to the best of my knowledge. I also agree to assume full Financial Responsibility for all the treatment rendered. A Finance Charge of 1½% or $1.00 min. (annual percentage rate 18%) will be added to accounts over 30 days old.

Signature ______________________ Date ______________

MEDICAL HISTORY

Are you in good health? YES ☐ NO ☐ If NO, EXPLAIN ______________________

List any drugs or medications you are presently taking ______________________

Do you now have or have you had any of the following? If YES, Please Describe.

Condition	YES	NO	Describe	Condition	YES	NO	Describe
Heart Disease	☐	☐		Shortness of Breath	☐	☐	
Chest Pains	☐	☐		Heart Murmur	☐	☐	
Rheumatic Fever	☐	☐		High Blood Pressure	☐	☐	
Tuberculosis	☐	☐		Anemia	☐	☐	
Diabetes	☐	☐		Epilepsy	☐	☐	
Ulcers	☐	☐		Liver Disease	☐	☐	
Asthma	☐	☐		Cancer	☐	☐	
Thyroid Trouble	☐	☐		Tumors	☐	☐	
Hepatitis	☐	☐		Radiation Treatment	☐	☐	
				Artificial Joints	☐	☐	

Do you have AIDS? YES ☐ NO ☐ Have you ever tested HIV positive? ☐ YES ☐ NO

Are you allergic to any medicines? YES ☐ NO ☐ Please list ______________________

Have you ever had prolonged bleeding following a tooth extraction? YES ☐ NO ☐

(Women) Are you pregnant? YES ☐ NO ☐

Are you under the care of a physician for anything not described above? YES ☐ NO ☐

Are you taking any kind of blood thinner? YES ☐ NO ☐

If yes, please describe ____

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