

GET-ACQUAINTED QUESTIONNAIRE

In order for us to better serve you, please fill in the following information completely:

(Complete Both Sides)

Mr.
Mrs.
Name Miss _____ Date of Birth _____

Home Phone _____ Cell Phone _____ Soc. Sec. No. _____

Address _____ City _____

State _____ Zip _____ Email address _____

Who may we thank for this referral? _____

Circle correct choice: Child Single Married Divorced Separated

Present Employer _____ Business Phone _____

Address _____

Spouse's Full Name _____

Spouse's Employer _____ Business Phone _____

Address _____

For Child or Teen, please list:

Father's Name _____ Business Phone _____

Mother's Name _____ Business Phone _____

Who may we contact in case of an emergency? _____ Phone _____

Who will be responsible for this account? _____

If insured, name of dental insurance company _____ Group # _____

MEDICAL HISTORY

Name and address of physician _____

When was your last physical examination? _____

Are you now under the care of a physician? Yes No

If yes, for what reason? _____

(Women) Are you pregnant? Yes No If yes, how long? _____

Have you ever had any other serious illness, hospitalization or accident? Yes No

If yes, please explain _____

Are you allergic to: Penicillin Codeine Local Anesthetic Latex Other _____

Are you currently taking any medication? _____

Do you smoke tobacco? _____ If yes, type _____ Frequency _____

Have you ever taken Phen-fen or Redux? Yes No

Do you have or have you ever had:

Heart disease / Heart Attack / Stroke	Yes	No	Arthritis / Rheumatism	Yes	No
Heart murmur	Yes	No	Kidney problems	Yes	No
Rheumatic fever	Yes	No	Fainting spells / Seizures / Epilepsy	Yes	No
Congenital heart defects / Mitral Valve Prolapse	Yes	No	Jaundice / Liver problems	Yes	No
Prosthetic implant.....	Yes	No	Hepatitis	Yes	No
Abnormal blood pressure High / Low	Yes	No	Asthma or hay fever	Yes	No
Ulcers / Stomache problems.....	Yes	No	Sinus problems	Yes	No
Tuberculosis or lung disease	Yes	No	Tumors / Cancer.....	Yes	No
Diabetes / Hypoglycemia	Yes	No	Stroke	Yes	No
Epilepsy	Yes	No	Glaucoma	Yes	No
Anemia	Yes	No	Radiation therapy / Chemotherapy	Yes	No
Thyroid problem.....	Yes	No	Psychiatric care	Yes	No
Chemical dependency	Yes	No	Tonsillitis.....	Yes	No
Excessive or prolonged bleeding	Yes	No	Neurologic problems	Yes	No
HIV / AIDS / ARC	Yes	No			

DENTAL HISTORY

Former Dentist _____ Address _____

When did you last visit a Dentist? _____ X-Rays taken? Yes No

Are you happy with the appearance of your teeth? Yes No

Are you aware of a dental problem? Yes No Explain _____

Do your gums bleed? Yes No

Have you ever been told you have gum disease? Yes No

Does food collect between your teeth? Yes No

Are your teeth sensitive to: Sweet Cold Heat Pressure

Do you clench or grind your teeth: Yes No

Do you have pain around your ears? Yes No

Unusual sounds in the ear? Yes No

Frequent blisters on lips or mouth? Yes No

Swelling or lumps in your mouth? Yes No

How often do you brush? _____ Use dental floss? _____

Anything else that would be valuable for me to know? _____

CONSENT FOR DENTAL TREATMENT

To the best of my knowledge the above statements are true and factual. Any misrepresentation releases liability of SBFD, PC and its employees. A comprehensive dental examination policy (3-12-97 S.B.D.E.) exists in our office. A modified or limited examination may be performed at my request which limits liability accordingly. I consent to allow the doctor to examine my oral conditions. Based on the results of the examination a diagnosis and proposed treatment plan and options including consequences of no treatment will be explained to me at which time it will be my choice to proceed.

I have received a copy of this office's Notice of Privacy Practices.

Signature _____ Date _____

Changes in Health _____ Date _____

Changes in Health _____ Date _____

Changes in Health _____ Date _____

Changes in Health _____ Date _____

Changes in Health _____ Date _____