Patient Acquaintance Form

Date:_____

Patient Information

Name:_____

Gender (M/F):_____ Birth Date:_____ Marital Status (M/S):_____

Social Security #:_____ Driver's License #:_____

Home Address:_____ City: State: Zip:

Name of employer:_____ Phone #: Work _____

Work Address:_____ City: State: Zip:

Phone #: Home _____ Cell_____ E-mail address_____

How would you like to receive confirmation of your appointment? E-mail · TEXT · Phone

Name of Person or Other Source Referring You to Our Practice:

Friend（Name: ） Doctor (Name:)

Advertisement ( ) · Internet · Direct-mail · Building · Neighbor

Others（ ）

Insurance Information

Name of Insurance Company:_____ Name of Insured:_____

Patient's Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other _____

Insured's Employer Name: _____ Insured's Social Security # : _____

Employer's Address:_____ Insured's Date of Birth: ____/____/____

Insured's Employer Tel. #: _____ Ext.:_____

Other Information

Date of Last Dental Visit: _____ Where? : _____

	Yes	No
01) Are you under any medical treatment now?	_____	_____
02) Have you had any major operations? If so what?	_____	_____
_____		
03) Have you had any serious head injuries?	_____	_____
04) Have you had any adverse reactions to any drugs?	_____	_____
05) Have you ever had any of the following? :		
Heart ailment/Heart attack?	_____	_____
Stroke?	_____	_____
Pacemaker?	_____	_____
High blood pressure?	_____	_____
Respiratory disease?	_____	_____
Asthma?	_____	_____
Sinus Problems?	_____	_____

	Yes	No
Tuberculosis?	_____	_____
Diabetes?	_____	_____
Rheumatic fever?	_____	_____
Rheumatism, arthritis or artificial Joints?	_____	_____
Tumors or cancers?	_____	_____
Any blood disease?	_____	_____
Anemia?	_____	_____
Any liver disease, hepatitis, Jaundice?	_____	_____
Any kidney disease?	_____	_____
Any stomach or intestinal disease?	_____	_____
Any venereal disease?	_____	_____
Epilepsy?	_____	_____
Glaucoma?	_____	_____
Excessive Bleeding?	_____	_____
AIDS?	_____	_____
Mental Disorders?	_____	_____
Nervous Disorders?	_____	_____
Chronic cough?	_____	_____
Codeine allergy?	_____	_____
Penicillin/Amoxicillin allergy?	_____	_____
06) Do you have night sweats or any weight loss?	_____	_____
07) Are you on a diet at this time?	_____	_____
08) Are you taking drugs or medications?	_____	_____
09) Drugs or Medications you are presently taking?	_____	
10) Are you allergic to any known materials (Ex. latex)?	_____	_____
11) Have any wounds healed slowly or any complications?	_____	_____
12) Do you have a history of fainting?	_____	_____
13) Have you had any X-ray treatment for tumors?	_____	_____
14) (For Women) Are you pregnant? Due Date _____	_____	_____
15) Are you in a habit of smoking?	_____	_____
16) Are you in general good health at this time?	_____	_____

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DENTAL HISTORY

	Yes	No
17) Do you have pain in or near your ears?	_____	_____
18) Do you have any unhealed injuries or inflammation in mouth?	_____	_____
19) Does any part of your mouth hurt when clenched?	_____	_____
20) Do you have any sore spots or tenderness in the mouth?	_____	_____
21) Any experience with dental anesthesia in the past?	_____	_____
22) Any allergic reactions to dental anesthesia?	_____	_____
23) Any difficult extractions in the past?	_____	_____
24) Prolonged bleeding following extractions in the past?	_____	_____

_____

Patient Signature *Date*

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient examination. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian _____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party _____ Date: _____ Relationship to Patient: _____