Shi·MI·zu
GENERAL & AESTHETIC DENTISTRY

ACQUAINTANCE FORM & HEALTH HISTORY

Patient Information

Name: _____

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

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

Home Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Name of employer: _____

Work Address: _____ City: _____ State: ____ Zip: _____

Work Phone: _____

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 ____ Neighbor ____

Others( )

Insurance Information

Name of Insurance Company: _____ Name of Insured: _____

Patient's Relationship to Insured: _____

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

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

Insured's Employer Tel #: _____

Dental History & Other Information

Date of Last Dental Visit: Where?:

	Yes	No
01. Do you have pain in or near your ears?	____	____
02. Do you have any unhealed injuries or inflammation in mouth?	____	____
03. Does any part of your mouth hurt when clenched?	____	____
04. Do you have any sore spots or tenderness in the mouth?	____	____
05. Any experience with dental anesthesia in the past?	____	____
06. Any allergic reactions to dental anesthesia?	____	____
07. Any difficult extractions in the past?	____	____
08. Prolonged bleeding following extractions in the past?	____	____

	Yes	No
09. Are you under any medical treatment now?	____	____
10. Have you had any major operations? If so what?	____	____
When? _____ What? _____		
11. Have you had any serious head injuries?	____	____
12. Have you had any adverse reactions to any drugs?	____	____
13. Have you ever had any of the following?	____	____
Heart ailment/Heart attack?	____	____
Stroke?	____	____
Pacemaker?	____	____
High blood pressure?	____	____
Respiratory disease?	____	____
Asthma?	____	____
Sinus Problems?	____	____
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?	____	____
HIV/AIDS?	____	____
Mental Disorders?	____	____
Nervous Disorders?	____	____
Chronic cough?	____	____
Codeine allergy?	____	____
Penicillin/Amoxicillin allergy?	____	____
	____	____
14. Do you have night sweats or any weight loss?	____	____
15. Are you on a diet at this time?	____	____
16. Are you taking drugs or medications?	____	____
17. Drugs or Medications you are presently taking?	____	____
18. Are you allergic to any known materials (Ex. latex)?	____	____
19. Have any wounds healed slowly or any complications?	____	____
20. Do you have a history of fainting?	____	____
21. Have you had any X-ray treatment for tumors?	____	____
22. (For Women) Are you pregnant? Due Date: _____	____	____
23. Are you in a habit of smoking?	____	____
24. Are you in general good health at this time?	____	____

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: _____

CLEAR ALL

PRINT