632 MONTGOMERY AVENUE, SUITE 2, NARBERTH, PENNSYLVANIA 19072 (610) 664-6061

ACQUAINTANCE FORM AND HEALTH QUESTIONNAIRE

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient. We look forward to working with you in maintaining your dental health.

GENERAL INFORMATION

E-mail Address _____

( ) Dr. ( ) Mr. ( ) Mrs. ( ) Ms._____ Birth Date_____
Last First Middle

Address_____
Number Street City/State Zip

_____
Home Telephone # Cell Telephone # Work Telephone #

Occupation _____ Social Security # _____

Employer _____ Business Address _____
Number/Street City/State Zip

Marital Status _____ Name of Spouse _____

Spouse's Occupation _____

If patient is a minor, who is legally responsible for treatment and payment? _____

_____
Relationship Number/Street City/State Zip Telephone #

Who may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone # _____

DENTAL INSURANCE INFORMATION

Name of **Dental** Insurance Carrier: _____ Agreement #: _____

Name of Group Dental Plan: _____ Group #: _____

Subscriber: _____ Subscriber's Social Security # _____

Subscriber's Employer: _____
Address Telephone #

Subscriber's Birth Date: _____

Has the patient had previous dental care under this plan? _____ Patient's Relationship to Subscriber: _____

Is the patient covered by another Dental plan? _____ If so, name of plan _____ Group # _____

Does patient have **medical** insurance? Yes: _____ No: _____

Insurance Company _____ Group # _____ Agreement # _____

MEDICAL/HEALTH HISTORY

Family Physician_____ Specialty: _____

Address _____ Telephone #: _____

Additional Physician _____ Specialty: _____

Address _____ Telephone #: _____

Height _____ Weight _____ Age: _____ Date of Last medical examination: _____

Yes No Have you been a patient in the hospital during the past two years? If yes, for what? _____
_____

Yes No Have you been under the care of a medical doctor during the past two years? If yes, for what? _____
_____

Yes No Have you ever had any excessive bleeding requiring special treatment? If yes, please describe _____
_____

Yes No Are you allergic (i.e. itching, rash, swelling of hands, feet or eyes) or made sick by any drug or medication? If yes, please list: _____
_____

Yes No Have you taken any medicine or drugs during the past two years? If yes, for what condition? _____
_____

Yes No Are you allergic to latex rubber? Yes No Are you taking Coumadin?

Please list medications currently taking (include over the counter drugs, herbal medicines and dietary supplements): ____
_____

Do you have any medical conditions not listed below? _____
_____

Circle any of the following which you have had or have at present:

Heart Murmur
Mitral Valve Prolapse
Heart Surgery
Heart Failure
Heart Disease or Attack
Heart Pacemaker
Coronary Occlusion
Congenital Heart Lesions
Rheumatic Fever
Scarlet Fever
Stroke
Artificial Heart Valve
Arteriosclerosis
Angina Pectoris
High Blood Pressure
Low Blood Pressure
Heart Problems
Describe _____
Insomnia
Ulcers
Tonsillitis
GERD (gastroesophageal reflux disease)

AIDS/HIV Positive
Genital Herpes
Venereal Disease
Cold Sores
Blood Transfusion
Hepatitis A (Infectious)
Hepatitis B
Hepatitis C
Hemophilia
Bruise Easily
Sickle Cell Disease
Anemia
Blood Disease
Alcoholism
Drug/Chemical Dependency
Cancer
Describe _____
Chemotherapy
Radiation Treatment
Thyroid Disease
Numbness

Arthritis
Artificial Joints
Rheumatism
Circulatory Problems
Allergies or Hives
Fainting/Dizzy Spells
Hay Fever
Sinus Trouble
Asthma
Persistent Cough
Respiratory Disease
Kidney Trouble
Liver Disease
Glaucoma
Emphysema
Epilepsy/Seizures
Diabetes
Tuberculosis (TB)
Contact Lenses
Pain in Jaw Joints (TMJ)
Tobacco Habit
None of the above _____

Are you on a special diet? ..... Yes No

Have you ever been involved in a serious accident? ..... Yes No
If yes, please describe _____

Do you take more than one alcoholic drink a day? _____ How many? _____

Do you use any tobacco products? _____ Which type? _____ How much? _____ How Long? _____

Women:
Are you pregnant now? ..... Yes No
Do you take birth control medication? ..... Yes No
Have you reached menopause? ..... Yes No
If so, are you taking supportive medication ..... Yes No

DENTAL HISTORY

What is your immediate dental concern? _____

_____

Primary Dentist: _____ Address: _____

Telephone #: _____ Period of treatment: _____ (Date)

Specialty Dentist: _____ Specialty: _____

Address: _____ Telephone #: _____

Date of last dental visit: _____ Date of last dental x-rays: _____

Please circle YES or NO. If YES, please fill in details.

Yes No Are you presently in any pain? _____

Yes No Have you ever experienced any unfavorable reaction to dentistry? _____

Yes No Have you ever had orthodontic treatment? _____ When? _____

Yes No Do you have any growths or swellings in your mouth? _____
How long have they existed? _____

Yes No Do you have any difficulty in swallowing? _____

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

Yes No Have you ever had a bad reaction to a dental anesthetic? _____ Describe: _____

Yes No Do you have any pain or soreness around your eyes or ears or other parts of your face? _____

Yes No Are you aware of stiff neck muscles? _____ How Often? _____

Yes No Do you ever awaken with an awareness of your teeth or jaw? _____ How Often? _____

Yes No Are you aware of clenching your teeth during your daytime hours? _____ How Often? _____

Yes No Have you ever been told you grind your teeth during sleep? _____ How Often? _____

Yes No Have you been diagnosed with sleep apnea? _____

Yes No Do you snore? _____

Yes No Are you aware of your jaw clicking or popping while eating or yawning? ____How Often? _____

Yes No Do you have difficulty in opening your mouth widely? _____

Yes No Do you have "tension" headaches? _____ How Often?_____

Yes No Are you dissatisfied with your teeth and their appearance? _____

Yes No Do you have any disease, condition, or problem not listed that you think we should know about?
If so, explain: _____

Yes No Do you feel very nervous about having dental treatment? If so, explain: _____
_____

Yes No Do you or your spouse have a history of periodontal disease? If so, explain: _____
_____

FINANCIAL POLICY STATEMENT

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. Charges not paid within 30 days of receipt of this statement are subject to a "Late Charge" 6% annually (or the maximum permitted by law).

If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you may be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred in collecting your account.

___ **There will be a charge for broken appointments or appointments cancelled without 24 hours notice.**
Initial

AUTHORIZATION

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and understand it is my responsibility to inform this office of any changes to the information I have provided.

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

I fully understand I am solely responsible for all charges whether or not paid by insurance and agree to the financial policy.

Patient's Signature _____ Doctor's Signature _____ Date ___/___/___

If you are completing this form for another person, what is your relationship to that person? _____