ACQUAINTANCE FORM

Glenn R Saraydar DDS

Healthy Beautiful Smiles

Date: _____

Patient Name: _____Preferred Name: _____Spouse_____

Address: _____ City: _____

State: _____ Zip: _____ Social Security Number: _____

Home Phone: _____Business Phone: _____Cell Phone:_____

Birth date: _____Age____ Marital Status: S___M___W___D___ Email _____

Employer: _____ Occupation/ or Retired from:_____

Business Address: _____

Person Responsible for Account: _____ Relation_____

Do you have Dental Insurance? _____Ins Company _____Phone_____

Whom may we thank for referring you to Dr. Saraydar? _____

Closest Relative _____Ph_____ Best way to contact you? _____

How can we make your appointments more comfortable? _____

Preferred Radio Station(s) or type of music? 89.7 92.5 98.7 99.5 100.7 101.5 103.5 104.7 Other_____

(Please Circle One)

1. My mouth is
   - A.) very comfortable
   - B.) moderately comfortable
   - C.) uncomfortable

2. I (I am)
   - A.) think the appearance of my mouth is excellent
   - B.) satisfied with the appearance of my mouth
   - C.) dissatisfied with the appearance of my mouth

3. I
   - A.) will do anything I can to keep my natural teeth
   - B.) want to keep my teeth, but will only budget a certain amount of time and money to spend on them regardless of the need
   - C.) don't care whether I keep my teeth or not

4. I
   - A.) have set goals for my oral health with a previous dentist
   - B.) want to set goals concerning my dental health
   - C.) never set goals concerning my dental health

5. I
   - A.) have always done the best that was recommended for my dental health
   - B.) have not done what dentists have recommended for my mouth
   - C.) rarely go, and don't care much about having my dental work completed.

6. I think my present state of dental health is
   - A.) excellent
   - B.) good
   - C.) poor

7. I aspire to a mouth with
   - A.) excellent health
   - B.) good health
   - C.) poor health

Who was your former Dentist? _____

Why did you change Dentists? _____

How long since your last dental appt? _____

What is/are your primary concerns?

_____

_____

1. Are you having pain or discomfort at this time? ___Yes___No Where?_____
2. Do you feel nervous about having dental treatment? ___Yes___No
3. Have you ever had a bad experience in a dental office? ___Yes___No _____
4. Have you been hospitalized in the past two years? ___Yes___No Reason?_____
5. Have you been under the care of a medical doctor during the past two years? ___Yes___No Reason?_____
6. Have you ever had Periodontal (Gum) Treatment? ___Yes___No When? _____
7. What are some questions about dentistry and oral health that you have never had adequately answered for you?

_____

Physician's Name _____ Physician's Phone _____

8. Have you taken any medications or drugs during the past two years? ___Yes___No Please List Below:

_____ _____

_____ _____

_____ _____

9. Are you now taking any vitamins, supplements, or herbal therapy? ___Yes___No List _____
10. Are you aware of being allergic to any of the following?

__ Penicillin __Erythromycin __Tetracycline __Sulfa __Keflex __Benzocaine __Topical Anesthetic __Aspirin __Local Anesthetic __Latex

11. Are you aware of being allergic to any **other** medication or substance? ___Yes___No If yes, list _____
12. Mark **"Y" for yes** and **"N" for no** for the following which you have had, or have at present:

__High Blood Pressure	**__Rheumatic Fever**	**__Radiation Therapy**	**__Cancer**	**__Cosmetic Surgery**
__Low Blood Pressure	**__Artificial Joints**	**__Chemotherapy**	**__if yes, what type_____**	**__Pain in Jaw Joints**
__Angina Pectoris	**__Diabetes**	**__Blood Transfusion**	**__Tuberculosis**	**__Thyroid Condition**
__Mitral Valve Prolapse	**__Anemia**	**__Seizures**	**__Emphysema/ COPD**	**__Nervousness**
__Heart Murmur	**__Hepatitis B or C**	**__Drug Addiction**	**__HIV Positive**	**__Psychiatric Tx**
__Heart Attack	**__Hepatitis A**	**__Fainting / Dizziness**	**__Leukemia**	**__Cortisone Medicine**
__Heart Pacemaker	**__Liver Disease**	**__Ulcers**	**__AIDS**	**__Allergies/Hives/Hay fever**
__Stroke	**__Yellow Jaundice**	**__Glaucoma**	**__Prolonged Cough**	**__ Hemophilia**
__ Heart Disease	**__Arthritis**	**__Cold Sores**	**__Head or Neck Trauma**	**__Asthma**

13. Do you ever have shortness of breath or chest pains? ___Yes___No _____
14. Do you have any **prosthetic heart valves**, **pins, plates, screws etc.?** ___Yes___No List_____
15. Have you ever had a **total joint replacement**? ___Yes___No How/why _____
16. Do your ankles swell during the day? ___Yes___No
17. Have you ever been treated with Bisphosphonates? ___Yes___No Fosamax, Aredia, Zometa, other?_____
18. Do you smoke? ___Yes___No How long_____ Packs/Day_____
19. Has your medical doctor ever said you have a **cancer or tumor**? ___Yes___No Type?_____
20. Do you have any **disease, condition, or problem not listed**? ___Yes___No What?_____
21. **Women only** Are you pregnant or think you may be? ___Yes___No
22. **Women only** Are you taking birth control pills? ___Yes___No

Consent: *The undersigned hereby authorizes the doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with (name of patient)_____ and further authorize consent that the doctor choose and employ such assistance as s/he deems fit.* ***I also understand the responsibility for payment for dental services provided in this office, for my dependents or myself, is mine and is due and payable at the time services are rendered.*** *In the event of default, I(we) promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees, as my be required, to effect collection of this note. If insurance is filed by this office it is done as a courtesy. I also understand that a* **Full Mouth Series of Radiographs is required by this office every 3-5 years, as well as annual Periodic Exams, in order to be a patient of record.**

*Signed by patient or parent/guardian*_____*Date*_____