DAVID R. LEONOFF, DDS, PC
Patient Acquaintance Form

Date: _____

Name_____Address_____

City_____State_____Zip_____Sex M/F____SS#_____ D/O/B_____

Home Phone #_____Work Phone #_____Cell#_____Marital Status____

Name of Insured_____Insured's SS#_____

Insured's address_____Insured's D/O/B_____

Insurance Carrier_____Policy/Group#_____

Insurance Carrier's address_____

Employer_____Employer's Phone#_____

Employer's address_____

E-Mail address_____

Referred By:_____

1. Do you need to pre-medicate with antibiotics for your dental appointments?....._____Yes _____No
2. Are you currently under the care of a physician?....._____Yes _____No
3. What are you currently being treated for?_____
4. Name and address of your physician_____
5. Have you recently had any serious illness or hospitalization?_____
6. If so, what was the illness/reason?_____
7. Are you currently taking any medication? (prescribed or not) YES NO (Circle One)
8. If so, what are you taking?_____

Does your medical history include any of the following:

9. Rheumatic or congenital (inborn) heart disease?....._____Yes _____No
10. Heart murmur, damaged or artificial heart valves?....._____Yes _____No
11. Cardiovascular disease (heart trouble)?....._____Yes_____No
12. High or low blood pressure?....._____Yes_____No
13. Do you have a cardiac pacemaker?....._____Yes_____No
14. Asthma, emphysema, or neurological disorders?....._____Yes_____No
15. Fainting, seizures, epilepsy, or neurological disorders?....._____Yes_____No
16. Diabetes?....._____Yes_____No
17. Hepatitis, jaundice, or other liver disease?....._____Yes_____No
18. Sexually transmitted disease?....._____Yes_____No
19. Aids or HIV infections?....._____Yes_____No
20. Thyroid problems?....._____Yes_____No
21. Stomach ulcer?....._____Yes_____No
22. Kidney trouble?....._____Yes_____No
23. Problems with mental health?....._____Yes_____No

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24. Cancer or treatment for tumor or growth?....._____Yes_____No
25. Problems of the immune system?....._____Yes_____No
26. Osteoporosis?....._____Yes_____No
27. Blood disorders, such as anemia?....._____Yes_____No
28. Abnormal bleeding?....._____Yes_____No
29. Have you ever required a blood transfusion?....._____Yes_____No
30. Do you have glaucoma?....._____Yes_____No
31. Have you had joint replacement surgery (knee, hip, etc.)?....._____Yes_____No

Are you allergic or have you ever had any reaction to:

32. Local anesthetics (novocaine)?....._____Yes_____No
33. Penicillin?....._____Yes_____No
34. Sulfa drugs or other antibiotics?....._____Yes_____No
35. Barbiturates, sedatives, or sleeping pills?....._____Yes_____No
36. Aspirin, acetaminophen (tylenol), or Advil (ibuprofen)....._____Yes_____No
37. Codeine or other narcotics?....._____Yes_____No
38. Any other drugs or medications?....._____Yes_____No

For Female Patients:

39. Are you pregnant?....._____Yes_____No
40. Are you nursing?....._____Yes_____No
41. Are you taking birth control pills?....._____Yes_____No

The medical information I have provided is correct.
I have listed all my known medical conditions, medications and allergies.

_____

Patient Signature (parent's signature if pt. is a minor) Date

FOR INSURANCE PROCESSING:

If you have dental insurance, you must sign the two items below. Otherwise we cannot send claims on your behalf and you would have to pay for your covered services in advance. You would then get reimbursed by your insurance company.

I authorize the release of any information relating to claims.
I understand that I am responsible for all costs of dental treatment.

_____

Patient Signature (parent's signature if pt. is a minor) Date

I hereby authorize payment of the dental benefits directly to the above named dental entity otherwise payable to me.

_____

Signature of Patient/ Insured person Date