



This Acquaintance Form will help us to serve you better. We will do our best to make your appointments as convenient and pleasant as possible. Please feel free to ask our staff if you have questions regarding your treatment, your appointments, or fees. We are glad you are here!

**PLEASE PRINT. FOR CHILDREN, 17 OR YOUNGER ONLY**

**Patient's Name** \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
First Name Middle Initial Last Name Month Day Year

Soc.Sec.No. \_\_\_\_\_ Home Phone No. \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

**Father's Name** \_\_\_\_\_ Soc.Sec.No. \_\_\_\_\_  
Birthdate \_\_\_\_\_ Home Phone # \_\_\_\_\_  
E-mail Address \_\_\_\_\_ Cell # \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Employer \_\_\_\_\_ Business Phone No. \_\_\_\_\_

**Mother's Name** \_\_\_\_\_ Soc.Sec.No. \_\_\_\_\_  
Birthdate \_\_\_\_\_ Home Phone # \_\_\_\_\_  
E-mail Address \_\_\_\_\_ Cell # \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Employer \_\_\_\_\_ Business Phone No. \_\_\_\_\_

**Subscriber's Name:** \_\_\_\_\_ **Subscriber's Birthdate:** \_\_\_\_\_  
Dental Insurance \_\_\_\_\_ Dental Ins. Phone \_\_\_\_\_  
Group # or Plan # \_\_\_\_\_ Subscriber ID# \_\_\_\_\_

**Person Responsible for Bill** \_\_\_\_\_ Birthdate \_\_\_\_\_  
Relationship to you \_\_\_\_\_ Soc.Sec.No. \_\_\_\_\_  
Billing Address \_\_\_\_\_ Phone No. \_\_\_\_\_  
Dental Insurance \_\_\_\_\_ Group No. or Plan No. \_\_\_\_\_

**Whom may we thank for referring you to us?** \_\_\_\_\_

**APPOINTMENTS:** We work by appointment only so your wait will be minimal and your treatment done efficiently. To help us serve you better we ask for 2 business days notice for changes in your appointment.

**INSURANCE:** To avoid misunderstanding regarding dental insurance, we want our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_  
(Parent or Guardian's signature)

**Patient's Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_  
First Name Middle Initial Last Name Month Day Year

**DENTAL HISTORY**

Please check any of the following your child ever had:

- Teeth sensitive to cold, heat, sweets, etc.
- Bleeding gums, How Long? \_\_\_\_\_
- Food impaction
- Clenching or grinding
- Burning of tongue
- Swelling or lumps in mouth
- Frequent blisters on lips or mouth
- Pain around ears
- Clicking or popping in ear while eating
- Bad Breath
- Unpleasant taste
- Complications from extractions
- Periodontal treatment
- Orthodontic treatment (braces)
- Mouth breathing
- Tongue thirst
- Oral habits, i.e. finger nail biting, cheek biting, ect.
- Thumb sucking

Please check any of the following your child uses:

- Dental floss
- Inter dental stimulators
- Water jet device
- Disclosing tablets or solutions
- Fluoride supplements
- Tooth brush, frequency of brushing? \_\_\_\_\_

**MEDICAL HISTORY**

Has your child had any of the following?

- |  |  |
|--|--|
| <input type="checkbox"/> Allergies to drugs WHICH? _____           | <input type="checkbox"/> Liver problems or hepatitis         |
| <input type="checkbox"/> Allergies to anesthetics WHICH? _____     | <input type="checkbox"/> Malinancies (cancer)                |
| <input type="checkbox"/> Any heart ailments                        | <input type="checkbox"/> Psychiatric care/emotional problems |
| <input type="checkbox"/> High blood pressure                       | <input type="checkbox"/> Rheumatic fever                     |
| <input type="checkbox"/> Neurological problems                     | <input type="checkbox"/> Sinus problems                      |
| <input type="checkbox"/> Radiation treatments                      | <input type="checkbox"/> Stroke                              |
| <input type="checkbox"/> Excessive bleeding from cut or extraction | <input type="checkbox"/> Thyroid problems                    |
| <input type="checkbox"/> Anemia or blood problems                  | <input type="checkbox"/> Eye disorders                       |
| <input type="checkbox"/> Arthritis                                 | <input type="checkbox"/> Tonsilitis                          |
| <input type="checkbox"/> Asthma                                    | <input type="checkbox"/> Tuberculosis                        |
| <input type="checkbox"/> Hay fever or other allergies              | <input type="checkbox"/> Ulcer of colitis                    |
| <input type="checkbox"/> Diabetes                                  | <input type="checkbox"/> Kidney problems                     |
| <input type="checkbox"/> Venereal disease                          | <input type="checkbox"/> Drug or Alcohol dependency          |
| <input type="checkbox"/> Acquired Immune Deficiency Syndrome       | <input type="checkbox"/> Epilepsy                            |

Physician's Name \_\_\_\_\_ Date of last physical exam \_\_\_\_\_

Pharmacy of Choice: \_\_\_\_\_ Phone # \_\_\_\_\_

Is your child presently under a physician's care? \_\_\_\_\_ If so, why? \_\_\_\_\_

Is your child presently taking any medications? \_\_\_\_\_ If so, why? \_\_\_\_\_

SIGNATURE \_\_\_\_\_

(Parent of Guardian's Signature)