



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 thrust
- 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"/> Malignancies (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"/> Tonsillitis |
| <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)