

Acquaintance Form

Personal Information

Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Birthdate: _____ Social Security Number: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Marital Status: Single Married Separated/Divorced Widowed
For whom may we thank for this referral? _____

Employment Information

Employer Name: _____ Occupation: _____
Employer Address: _____
City: _____ State: _____ Zip: _____

Insurance and Financial

Person Responsible for Account: _____
Insurance Company: _____
Policy Number: _____ Group Number: _____
Policy Holder Social Security Number: _____ Policy Holder Birthdate: _____

Medical History

Are you currently taking any medications? **Y/N** *If yes, what?* _____

Are you allergic to any medications? **Y/N** *If yes, what?* _____

Any recent serious illness? **Y/N** *If yes, what?* _____

Any history of (check all that apply). It is **EXTREMELY** important to indicate if you have or have had one of the conditions in **BOLD**.

- | | | |
|---|---|---|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Artificial Heart Valve(s) |
| <input type="checkbox"/> Artificial Joint(s) | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Other Cardiac Problems |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Anesthetic Allergy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> STDs | <input type="checkbox"/> Drug or Alcohol Addiction |
| <input type="checkbox"/> Drug Allergy | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer |

Do you smoke? **Y/N** If you smoke, do you want to quit? **Y/N**

Physician's Name: _____ Date of Last Visit: _____

Signature (or legal guardian signature): _____ **Date:** _____

Our office is dedicated to the concept that all people should have the right to retain their natural teeth for a lifetime. Preventive measures, high-quality care, and good cooperation combined with timely treatment make it possible for most people to retain their natural teeth with optimum comfort, function, and appearance. My staff and I are dedicated to this concept and with your cooperation we will do everything we can to help your goals for dental health.