MASHNI DENTISTRY

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ACQUAINTANCE FORM

This information will help us give you the most consideration of your time and feelings, and is, of course, confidential. It is important to give complete answers.

Patient's Name _____ Date _____

Sex: q M q F By what name would you like us to call you? _____

Home Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

E-mail _____ Date of Birth _____ Marital Status _____

Name & telephone of someone not living with you to contact in case of an emergency:

_____

Whom may we thank for referring you to our office? _____

ACCOUNT INFORMATION

Employer _____

Occupation _____ SS# _____

Person responsible for account _____

DENTAL INSURANCE INFORMATION

Subscriber's Name _____ SS# _____

Employer _____ Group Number _____ Date of Birth _____

Name of Dental Insurance Co. _____

Address _____

Subscriber's Address (if different from above) _____

SECONDARY DENTAL INSURANCE INFORMATION

Subscriber's Name _____ SS# _____

Employer _____ Group Number _____ Date of Birth _____

Name of Dental Insurance Co. _____

Address _____

Subscriber's Address (if different from above) _____

DENTAL HISTORY

1. Last dental visit? _____
2. What was done at last appointment? _____
3. Do you have any dental concerns? _____
4. How long have you had this/these concerns? _____
5. Are you aware of any clenching or grinding? _____
6, Do your gums bleed when you brush or floss? _____ How Long _____
7. Are you happy with the appearance of your smile? _____
8. If not, what would you change? _____
9. Have you set goals for your dental health with previous dentist? _____
10. Have you ever been told you have bad breath? _____
11. Have you ever been told you have periodontal or gum disease? _____
12. Are you aware of how dental health is related to general health? _____
13. The most important thing to me about my dental visit is:
    A. Time
    B. Money
    C. Comfort
14. Previous dental visits have been:
    A. Good
    B. Bad
    C. Indifferent
15. What are some questions about dentistry and oral health that you never had adequately answered for you? ___

_____

_____

_____

MEDICAL HISTORY

Date of last medical examination _____ Physician's Name _____

Are you under the care of a physician now? _____ For what reason? _____

Please check the proper answer if you have had any of the following:

YES	NO	
q	q	scarlet fever, rheumatic fever, heart murmur
q	q	angina, chest pain
q	q	heart attack, stroke
q	q	swelled ankles, shortness of breath
q	q	abnormal bleeding, prolonged healing
q	q	sinus problems
q	q	fainting, seizures, epilepsy
q	q	hepatitis, jaundice, liver disease
q	q	tuberculosis, lung disease
q	q	neck ache, back ache
q	q	radiation treatment for tumor or other growth
q	q	surgery involving heart valves, pins, joint replacement, etc.
q	q	diabetes, if yes, your A1C level _____
q	q	high blood pressure
q	q	low blood pressure
q	q	anemia
q	q	ulcers
q	q	asthma, hay fever
q	q	arthritis
q	q	kidney problems
q	q	persistent cough
q	q	migraine headaches
q	q	HIV, venereal disease
q	q	Are you aware, or have you been told you snore
q	q	Have you ever had a sleep study

Please list the medications that have been prescribed by your doctor:

Medication	Dose/Frequency	Why do you take it?

Please list the medications that you have selected on your own (also called "over-the-counter" or OTC). These might include medicines for pain or headache (Tylenol, Motrin ib, Advil), stomach problems (Maalox, Pepto Bismol, Zantac), cough or cold symptoms (Robitussin, Dimetapp, Sudafed), allergies (Benadryl), etc.

Medication	Dose/Frequency	Why do you take it?

Please list the herbs or other all-natural supplements that you are taking (such as Ginseng, St. Johns wort, Saw Palmetto, bilberry, etc.):

Name of Herb	Dose/Frequency	Why do you take it?

Do you have any illness, condition or problems not listed above that the doctor should be aware of?

_____

Women: Are you pregnant? _____ Due Date _____

Do you smoke? _____ Packs per day? _____ Use smokeless tobacco? _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
q	q	Penicillin	q	q	Sulfa	q	q	Novocaine
q	q	Codeine	q	q	Aspirin	q	q	Other anesthetics
q	q	other drugs _____						

Patient's signature _____ Date _____

(if child, parent or guardian)

Reviewed by _____ Date _____