

# Acquaintance Form & Health History

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Marital Status \_\_\_\_\_

Nickname, if preferred \_\_\_\_\_ Spouse's name (if married) \_\_\_\_\_

Date of birth \_\_\_\_\_ Residence \_\_\_\_\_  
Street address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell # \_\_\_\_\_ Employer \_\_\_\_\_

Position or Occupation \_\_\_\_\_ Length of Employment \_\_\_\_\_

Business Phone \_\_\_\_\_ Business Address \_\_\_\_\_

Emergency Name & Phone No. \_\_\_\_\_

Person Responsible for Account \_\_\_\_\_ Referred by \_\_\_\_\_

Dental Insurance Yes \_\_\_ No \_\_\_ \*\* If yes, please present card to receptionist

If someone other than yourself is the policy holder, please list that person's date of birth \_\_\_\_\_

Social Security No. \_\_\_\_\_ Policyholder's Social Security No. \_\_\_\_\_

1.) What prompted you to seek dental care at this time? \_\_\_\_\_

2.) Date of your last thorough dental examination & cleaning? \_\_\_\_\_

3.) How frequently do you have your teeth examined? \_\_\_\_\_ cleaned? \_\_\_\_\_ x-rayed? \_\_\_\_\_

4.) Has fear of discomfort kept you from regular dental visits? \_\_\_\_\_

5.) Are you satisfied with your past dentistry? \_\_\_\_\_

6.) How often do you brush your teeth? \_\_\_\_\_ Dental Floss? \_\_\_\_\_

7.) Are you troubled with bad breath? \_\_\_\_\_

8.) Do your gums bleed easily, or feel tender? \_\_\_\_\_

9.) Are your teeth sensitive to hot, cold, or sweets? \_\_\_\_\_

- 10.) Do you frequently snack between meals? \_\_\_\_\_
- 11.) Are you self-conscious about the appearance of your teeth? \_\_\_\_\_
- 12.) Would you like to retain your healthy natural teeth as long as possible? \_\_\_\_\_
- 13.) Do your jaws feel tired? \_\_\_\_\_
- 14.) Do you have pain, frequent headaches or pain in neck, shoulders, or back? \_\_\_\_\_
- 15.) Do you have clicking or popping noises when opening or closing your mouth? \_\_\_\_\_
- 16.) Are you aware of grinding or clenching your teeth? \_\_\_\_\_
- 17.) Name of your previous dentist \_\_\_\_\_
- 18.) May we request your previous dental records to facilitate proper treatment in our office? \_\_\_\_\_
- 19.) Would you like to receive correspondence via e-mail? Yes \_\_\_ No \_\_\_  
E-mail address \_\_\_\_\_

Are you under a physician's care now? Yes No If yes, please list reason:

Have you ever been hospitalized or had a major operation? Yes No If yes, please list:

Have you ever had a serious head injury? Yes No If yes, please explain:

Are you taking any medications? Yes No If yes, please list:

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes, when?

Are you on a special diet? Yes No If yes, please explain:

Do you use tobacco? Yes No If yes, how often? \_\_\_\_\_

Women, are you: pregnant or trying to get pregnant?  
nursing?  
taking oral contraceptives?

Are you allergic to any of the following: Aspirin Penicillin Codeine Acrylic Metal  
Latex Local Anesthetics Other (please specify) \_\_\_\_\_

Do you have, or have you had, any of the following: (please circle)

- |                           |                           |                            |
|---------------------------|---------------------------|----------------------------|
| AIDS/HIV Positive         | Excessive Thirst          | Mitral Valve Prolapse*     |
| Alzheimer's Disease       | Fainting Spells/Dizziness | Pain in Jaw Joints         |
| Anaphylaxis               | Frequent Cough            | Parathyroid Disease        |
| Anemia                    | Frequent Diarrhea         | Psychiatric Care           |
| Angina                    | Frequent Headaches        | Radiation Treatments       |
| Arthritis/Gout            | Genital Herpes            | Recent Weight Loss         |
| Artificial Heart Valve*   | Glaucoma                  | Renal Dialysis             |
| Artificial Joint*         | Hay Fever                 | Rheumatic Fever*           |
| Asthma                    | Heart Attack/Failure      | Rheumatism                 |
| Blood Disease             | Heart Murmur*             | Scarlet Fever              |
| Blood Transfusion         | Heart Pace Maker*         | Shingles                   |
| Breathing Problem         | Heart Trouble/Disease     | Sickle Cell Disease        |
| Bruise Easily             | Hemophilia                | Sinus Trouble              |
| Cancer                    | Hepatitis A               | Spina Bifida               |
| Chemotherapy              | Hepatitis B or C          | Stomach/Intestinal Disease |
| Chest Pains               | Herpes                    | Stroke                     |
| Cold Sores/Fever Blisters | High Blood Pressure       | Swelling of Limbs          |
| Congenital Heart Disorder | Hives or Rash             | Thyroid Disease            |
| Convulsions               | Hypoglycemia              | Tonsilitis                 |
| Cortisone Medicine        | Irregular Heartbeat       | Tuberculosis               |
| Diabetes                  | Kidney Problems           | Tumors or Growths          |
| Drug Addiction            | Leukemia                  | Ulcers                     |
| Easily Winded             | Liver Disease             | Venereal Disease           |
| Epilepsy or Seizures      | Low Blood Pressure        | Yellow Jaundice            |
| Excessive Bleeding        | Lung Disease              |                            |

Have you had any serious illness not listed above?    Yes    No    If yes, please explain:

---

***\*Condition may require medication***

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

---

**Signature of Patient, Parent or Guardian**

**Date**