Date: _____ PATIENT ACQUAINTANCE FORM

Name: _____

Preferred Name: _____

Address: _____

City: _____State: _____ Zip: _____

C Phone: _____ H or W phone: _____

Email address: _____ Place of employment: _____

Social Security Number: _____Birthdate: _____ Sex: _____

Marital Status: _____ Name of Responsible Party: _____

Referred by: _____General Dentist: _____

Pharmacy Name/Number: _____ Emergency Contact: _____

Health History

1. Are you in general good health? ..... _____Yes _____No
2. Have you ever been hospitalized for any illness or operation? ..... _____Yes _____No
3. Are you taking antibiotics, sulfa drugs, or anticoagulants? ..... _____Yes _____No
4. Are you taking blood pressure medicine tranquilizers or iodine? ..... _____Yes _____No
5. Are you taking codeine, narcotics, or any other drug? ..... _____Yes _____No
6. Do you wear glasses and/or contacts? ..... _____Yes _____No
7. Do you drink alcohol? ..... _____Yes _____No
8. Do you smoke or use smokeless tobacco? ..... _____Yes _____No
9. Are you pregnant or nursing? ..... _____Yes _____No
10. Do you have any menstrual problems, take oral contraceptives, or are you on hormone therapy? ..... _____Yes _____No
11. Are you experiencing oral pain, headaches, earaches, or neck pains? ..... _____Yes _____No
12. Are you currently or have you ever taken bisphosphonates (drugs like Actonel, Fosamax, etc. to increase bone density)?... _____Yes _____No
13. **Please list all medications (prescription and over the counter), the dosage, and the reason for taking the medication.**

_____

_____

_____

Dental History

1. Are you happy with the appearance of your teeth? _____Yes _____No

2. Are you able to eat whatever you want and function comfortably with your teeth? _____Yes _____No

3. What changes or improvements would you like to have for your smile? _____
_____

4. What is the reason for your visit to our office today? _____
_____

Please circle any of the following that you have had or presently have:

Abnormal Bleeding/surgery	Emotional disturbances	Liver Disease
AIDS/HIV infected	Emphysema	Osteoporosis
Anemia	Epilepsy/seizures/fainting spell s Pacemaker	Persistent cough or cold
Arthritis	Family history of blood disorders	Sexually transmitted disease
Asthma	Glaucoma	Shortness of breath on exertion
Blood Pressure Problems	Heart Attack/trouble/damaged valve	Sickle Cell
Blood Transfusion	Hepatitis A,B,C,D	Sinus Trouble
Chemotherapy	Hemophiliac	Heart Murmur
Chronic Bronchitis	Herpes	Stomach Ulcers
Congenital/Rheumatic heart disease	Hyper/Hypo thyroidism	Stroke
Coronary insufficiency	Joint replacement	Kidney trouble
Diabetes	Tuberculosis	Tumors/Malignancy
		Vomited Blood

Please list any medical conditions or diseases not circled above: _____

_____

_____

Are you allergic to or have you reacted adversely to any of the following:

Aspirin	Codeine	Erythromycin	Penicillin	Sleeping Pills
Barbiturates	Dental anesthetics	Iodine	Sedatives	Sulfa Drugs

Please list any known drug or other allergies not circled above: _____

_____

Upon acceptance of treatment, I hereby authorize and request the performance of dental services for myself. I also give my consent to any advisable dental procedures, medications or anesthetics to b e administered by Dr. Ken Parrish or by his supervised staff for diagnostic purposes or dental treatment. These records may include study models, photos, x-rays and blood studies. I understand and acknowledge that I am financially responsible for the services provided for myself regardless of insurance coverage. I give Dr. Ken Parrish permission to use any photographs or other dental records for display or for instruction with other dentists who may be in training. To the best of my knowledge, the information provided is accurate.

"The above is a full disclosure of my total medical history. I will immediately inform of the office of any changes to my medical history or status."

Signed: _____