

# PATIENT ACQUAINTANCE FORM



## Patient Information

Date \_\_\_\_\_ Male or Female (circle) \_\_\_\_\_

Patient's Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Adopted \_\_\_\_\_

Social Security # \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Relatives Treated Here \_\_\_\_\_

If patient is a minor, give parent's or guardian's name \_\_\_\_\_

Patient's Dentist \_\_\_\_\_ City \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

## Medical History

Is patient in good health?  Yes  No

Please check box if patient has or has had:

<input type="checkbox"/> Joint swelling	<input type="checkbox"/> Bone disorders	<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Malignancies
<input type="checkbox"/> Kidney involvement	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Anemia	<input type="checkbox"/> Emotional problems	<input type="checkbox"/> Measles
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Prolonged bleeding	<input type="checkbox"/> Faintness/Dizziness	<input type="checkbox"/> Asthma	<input type="checkbox"/> Mumps
<input type="checkbox"/> Depression	<input type="checkbox"/> Endocrine problems	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Tonsils removed	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Liver involvement	<input type="checkbox"/> Stroke	<input type="checkbox"/> Circulatory problems	<input type="checkbox"/> Adenoids removed	<input type="checkbox"/> Sinus problems
			<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ulcer
				<input type="checkbox"/> Typhoid fever

Does patient have tendency to colds?  Sore Throats  Ear Infections

List any allergies or medications now being taken. Give reasons: \_\_\_\_\_

List any other serious illnesses: \_\_\_\_\_

Is patient under physician's care presently?  No  Yes Reason \_\_\_\_\_

Name of physician \_\_\_\_\_

Does patient wear contact lenses?  Yes  No

Does patient gag easily?  Yes  No

Additional comments: \_\_\_\_\_

## Dental History

Please check box if answer is YES:

<input type="checkbox"/> Any injuries to face, mouth, teeth? (circle)	<input type="checkbox"/> Thumb, finger, lip sucking? (circle)
<input type="checkbox"/> Mouth breathing when asleep, awake? (circle)	<input type="checkbox"/> Any missing permanent teeth?
<input type="checkbox"/> Any extra permanent teeth?	<input type="checkbox"/> Any teeth removed by extraction?
<input type="checkbox"/> Is there a tongue-thrust problem?	<input type="checkbox"/> Any speech problems?
<input type="checkbox"/> Any pain or clicking on opening mouth?	
<input type="checkbox"/> Does patient visit dentist regularly? Date of last dental visit _____	
<input type="checkbox"/> Has an orthodontist been consulted previously? Reason: _____	

List any musical instruments played: \_\_\_\_\_

What would you like to have orthodontic treatment accomplish? \_\_\_\_\_

## Emergency Information

Name of nearest relative not living with you \_\_\_\_\_

Complete Address \_\_\_\_\_

Phone \_\_\_\_\_



### Responsible Party Information

Name \_\_\_\_\_ Marital Status S M D  
Last First Middle

Mailing Address \_\_\_\_\_  
Street City State Zip

How long at this address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Previous Address (if less than 3 years) \_\_\_\_\_  
Street City State Zip

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Last First Middle

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

### Insurance Information

Insured's Name \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Do you have dual coverage? Yes  No  **IF YES:** Please answer following questions:

Insured's Name \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Insured's Employer \_\_\_\_\_

### Office Financial Policy

- Payment for diagnostic records are due the DAY they are taken.
- Payment of fees are the responsibility of the above stated INDIVIDUAL (Patient)/Parent/Guardian/Responsible Individual) **NOT THE INSURANCE COMPANY.**
- Insurance assignments and payments to the doctor are arranged on an individual basis and will be discussed and arranged prior to any services.
- Balances remaining after insurance payments or denial of insurance benefits will be the responsibility of the above stated INDIVIDUAL.

I understand that where appropriate, credit bureau reports may be obtained.

**SIGNATURE** (Parent's signature if minor) \_\_\_\_\_

Updates (date & initial) \_\_\_\_\_