GET ACQUAINTED QUESTIONNAIRE...

DATE

LAST NAME | FIRST | MIDDLE | MARITAL STATUS | DATE OF BIRTH

ADDRESS | STREET | CITY | STATE | ZIP | NAME OF SPOUSE

HOME PHONE | CELL PHONE | BUSINESS PHONE | EMAIL

PERSON RESPONSIBLE FOR ACCOUNT | ADDRESS | CITY

EMPLOYER | OCCUPATION

BUSINESS ADDRESS | CALIFORNIA DRIVER'S LICENSE # | SOCIAL SECURITY #

ARE YOU COVERED BY DENTAL INSURANCE? ❑ YES ❑ NO | IF SO, BY WHOM? | GROUP NUMBER

IF SO, IDENTIFICATION NUMBER

NAME OF RELATIVE OR CLOSE FRIEND | ADDRESS | PHONE

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? | ADDRESS

WHO IS YOUR PHYSICIAN? | WHEN WAS YOUR LAST VISIT? | WHO WAS YOUR FORMER DENTIST? | WHEN WAS YOUR LAST DENTIST VISIT?

MEDICAL HISTORY...

HAVE YOU HAD ANY SERIOUS ILLNESS OR OPERATION? IF YES, PLEASE DESCRIBE.

HAVE YOU EVER HAD A BLOOD TRANSFUSION? ❑ YES ❑ NO | IF YES GIVE APPROXIMATE DATE(S)

(WOMEN) ARE YOU PREGNANT? ❑ YES ❑ NO | NURSING? ❑ YES ❑ NO | TAKING BIRTH CONTROL PILLS? ❑ YES ❑ NO

PLEASE CHECK YES/NO INDICATING IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING...

	YES/NO		YES/NO		YES/NO		YES/NO
AIDS/HIV Positive	❑ ❑	Cortisone Treatment	❑ ❑	Heart Conditions	❑ ❑	Radiation Treatment	❑ ❑
Anemia	❑ ❑	Cough, Persistent	❑ ❑	Hemophilia	❑ ❑	Respiratory Disease	❑ ❑
Arthritis, Rheumatism	❑ ❑	Cough up Blood	❑ ❑	Hepatitis	❑ ❑	Shingles	❑ ❑
Artificial Heart Valves	❑ ❑	Dementia	❑ ❑	Herpes	❑ ❑	Shortness of Breath	❑ ❑
Allergies	❑ ❑	Diabetes	❑ ❑	High/Low Blood Pressure	❑ ❑	Skin Rash/Hives	❑ ❑
Asthma/Emphysema	❑ ❑	Dialysis	❑ ❑	Intestinal /Stomach Disease	❑ ❑	Stroke	❑ ❑
Back Problems	❑ ❑	Epilepsy/Seizures	❑ ❑	Joint Replacement	❑ ❑	Swelling of Feet or Ankles	❑ ❑
Bisphosphonates	❑ ❑	Fen-Phen/Redux	❑ ❑	Kidney Disease	❑ ❑	Thyroid Problems	❑ ❑
Blood Disease/Leukemia	❑ ❑	Fainting/Dizziness	❑ ❑	Liver Disease	❑ ❑	Tobacco Habit	❑ ❑
Cancer	❑ ❑	Glaucoma	❑ ❑	Osteoporosis	❑ ❑	Tonsillitis	❑ ❑
Chemical Dependency	❑ ❑	Headaches	❑ ❑	Other _____	❑ ❑	Tuberculosis	❑ ❑
Chemotherapy	❑ ❑	Describe _____		Pacemaker	❑ ❑	Ulcer	❑ ❑
Circulatory Problems	❑ ❑	_____		Psychiatric Care	❑ ❑	Venereal Disease	❑ ❑

MEDICATIONS...

LIST ANY MEDICATIONS OR SUPPLEMENTS YOU ARE CURRENTLY TAKING

PHARMACY NAME

PHARMACY PHONE

ALLERGIES...

❑ Aspirin ❑ Penicilin

❑ Barbituates (Sleeping pills) ❑ Sulfa

❑ Codeine ❑ Latex

❑ Local Anesthetic ❑ Other _____

To the best of my knowledge I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's Signature_____ Date_____

RECALL REVIEW:

1. Patient's Signature_____ Date_____

2. Patient's Signature_____ Date_____

3. Patient's Signature_____ Date_____