Patient Acquaintance Form

Patient Name_____Date of Birth____/____/_____Male ☐ Female ☐
Address_____SS#_____-_____-_____
City_____State_____Zip_____
Home Phone_____Cell Phone_____
Email address_____
*Person responsible for account, if different from above_____
*Date of Birth____/____/_____ SS#_____-____-_____ Phone Number(s)_____
*Address, if different from above _____

Dental Insurance Company Name_____ Policy holder's name_____
Employer of Policy holder _____
Policy holder's Date of Birth_____/_____/_____Policy holder's SS#_____-_____-_____

Are you requesting to see a specific dentist today, if so, who?_____

How did you hear about our office?_____

Health History (all information is kept strictly confidential)

Your physician's name_____**Are you pregnant?** YES___ NO___ Due Date_____
YES____NO____**Are you currently being treated?** (If yes, why?)_____
YES____NO____**Are you currently on any medications?** (If yes, please list)_____
YES____NO____**Are you allergic to ANYTHING?** (If yes, please list) _____
YES____NO____**Have you had any recent surgeries or illnesses?** _____
Do you need to <u>premed</u> to have dental work done? YES____NO ____ If unsure, read the following questions.
*Do you have a prosthetic cardiac valve? YES____NO____
*Have you had previous infective endocarditis? YES____NO____
*Do you have congenital heart disease? YES____NO____
*Have you had any joints replaced? YES____NO____ When?_____What joint?_____
*Have you had a **surgery** or a **heart attack** within the last 3 months? NO____YES____DATE_____

Please check if ANY of the following are applicable:

____arthritis
____asthma
____cancer (date)_____Treatment completed_____
____currently taking blood thinners_____
____dental anxiety
____diabetes
____epilespsy or seizures
____head or neck injury (date) _____
____heart problems
____hepatitis (date)_____Type_____
____high or low blood pressure (circle one)
____HIV positive (AIDS or ARC)
____ kidney or liver disease (circle one)
____mental health concerns_____
____mitral valve prolapse
____oral or IV administered Bisphosphanates
____prolonged bleeding
____rheumatic heart disease w/heart murmur
____sinus trouble
____smoke or use other forms of tobacco
____thyroid disease
____tuberculosis (date) _____
____alcoholism or chemical dependency
____other_____

**MY SIGNATURE BELOW AUTHORIZES ASSOCIATED DENTISTS OF RIVER FALLS TO PROVIDE NECESSARY INFORMATION TO, SUBMIT CLAIMS TO AND RECEIVE PAYMENTS FROM MY INSURANCE COMPANY.
**ASSOCIATED DENTISTS WILL CHARGE A 1% MONTHLY FINANCE FEE FOR ALL UNPAID ACCOUNTS.

Signature_____**Date**_____
(Parent or guardian if patient is a minor)

Our office is dedicated to the concept that all people have the right to retain their natural teeth for a lifetime. Preventative measures, high quality care and good cooperation combined with timely treatment make it possible for most people to retain their natural teeth with optimum comfort, function and appearance. With your cooperation we will do everything we can to help you reach your goals for dental health.