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 you 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 you snore when you sleep? _____

14.) Do others wake you up from sleeping because you're snoring? _____

15.) Do your jaws feel tired? _____

16.) Do you have pain, frequent headaches or pain in neck, shoulders, or back?
_____

17.) Do you have clicking or popping noises when opening or closing your mouth?
_____

18.) Are you aware of grinding or clenching your teeth? _____

19.) Name of your previous dentist: _____

20.) May we request your previous dental records to facilitate proper treatment in our office?
_____

21.) Would you like to receive correspondence via e-mail? Yes ___ No ___

E-mail address _____

22.) Preferred Pharmacy? _____
Pharmacy Address? _____
Pharmacy Phone Number? _____