WELCOME TO OUR OFFICE

Get Acquainted Card

PATIENT'S NAME _____ BIRTHDATE _____

SS# _____ MALE___ FEMALE___ PARENT'S NAME (IF CHILD) _____

SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED ❑

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE NUMBER _____ CELL PHONE NUMBER _____

WHICH TELEPHONE MAY WE CONTACT YOU AT? _____

MAY WE LEAVE A DETAILED MESSAGE ON YOUR ANSWERING MACHINE? _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ OFFICE PHONE NUMBER _____

_____

INSURED'S NAME _____ BIRTHDATE _____

INSURED'S EMPLOYER _____ SS# _____

PRIMARY DENTAL INSURANCE _____

GROUP NUMBER _____ TELEPHONE NUMBER _____

ADDRESS _____

SECONDARY DENTAL INSURANCE _____

GROUP NUMBER _____ TELEPHONE NUMBER _____

ADDRESS _____

INSURED'S NAME FOR SECONDARY COVERAGE _____

SS# _____ DATE OF BIRTH _____

INSURED'S EMPLOYER _____

DATE OF LAST MEDICAL EXAM _____ REASON _____

MEDICAL DOCTOR'S NAME _____

LOCATION _____

MEDICAL INSURANCE COMPANY _____

GROUP NUMBER _____

ADDRESS _____

MEMBER'S NAME _____

SS# _____ DATE OF BIRTH _____

REFERRED BY _____

DO YOU HAVE A FAMILY MEMBER THAT IS AN ESTABLISHED PATIENT HERE? YES ❑ NO ❑

NAME _____

PLEASE TURN CARD OVER TO CONTINUE WITH HEALTH HISTORY

Thank You

PLEASE ANSWER EACH QUESTION

	No	Yes
Poor health	❑	❑
Recent illness	❑	❑
Recent cough or cold	❑	❑
Nose obstruction	❑	❑
Heart or chest pain	❑	❑
Frequent swollen ankles	❑	❑
Acid Reflux	❑	❑
Diverticulitis	❑	❑
Bleeding tendency	❑	❑
Herpes	❑	❑
Hepatitis	❑	❑
Do you take appetite suppressant drugs?	❑	❑
Do you take barbiturates (sleeping pills)?	❑	❑

	No	Yes
Asthma	❑	❑
Diabetes	❑	❑
Mitral Valve Prolapse	❑	❑
Heart trouble	❑	❑
High Blood Pressure	❑	❑
Kidney Disease	❑	❑
Liver Disease	❑	❑
Krohn's Disease	❑	❑
Lung Disease	❑	❑
Bronchitis	❑	❑
Rheumatic fever	❑	❑
Convulsions	❑	❑
HIV Positive	❑	❑

	No	Yes
AIDS	❑	❑
Anemia	❑	❑
Allergy to :		
Latex	❑	❑
Penicillin	❑	❑
Sulfa	❑	❑
Novocaine	❑	❑
Codeine	❑	❑
Aspirin	❑	❑
Household Bleach	❑	❑
Other drugs	❑	❑

Do you use tobacco products?	❑	❑
Are you under the care of a physician?	❑	❑
Have you had a heart valve replacement?	❑	❑
Have stents been placed?	❑	❑
Do you have a pacemaker?	❑	❑

If so, when was it placed? _____

Are you now or have you ever received chemotherapy?	❑	❑

If yes, what type of drugs were used and the name & telephone of your Oncologist?

_____

_____

Must you sleep with your head on more than one pillow?	❑	❑
Have you ever been put to sleep for an operation?	❑	❑
If female - are you pregnant?	❑	❑
Are you under the care of a physician?	❑	❑
Have you ever responded unfavorably to medical or dental care?	❑	❑
Do you get short of breath after a little exertion?	❑	❑
Have you been hospitalized within the last 5 years?	❑	❑
Have you ever been diagnosed with osteoporosis?	❑	❑

If yes, list of medication: _____

_____

Do you have an artificial joint replacement?	❑	❑

If yes, which joint and when? _____

Were there any problems after surgery? _____

Blood Pressure _____

List medications you are currently taking including herbal supplements: _____

_____

Update: _____

_____

Describe medical conditions not listed above: _____

_____

_____

HISTORY CHART Reviewed by _____ Title or Relationship _____

Signature _____ Date _____