

This Acquaintance Form will help us to serve you better. We will do our best to make your appointments as convenient and pleasant as possible. Please feel free to ask our staff if you have questions regarding your treatment, your appointments, or fees. We are glad you are here! **PLEASE PRINT. FOR CHILDREN, 17 OR YOUNGER ONLY**

Patient's Name	_ Birthdate Age Sex	
First Name Middle Initial Last Name	Month Day Year	
Soc.Sec.No	Home Phone No	
Home Address	CityZip	
Father's Name	Soc.Sec.No	
Birthdate	Home Phone #	
E-mail Address	Cell #	
Home Address	CityZip	
Employer	Business Phone No	
Mother's Name	Soc.Sec.No	
Birthdate	Home Phone #	
E-mail Address	Cell #	
Home Address	CityZip	
Employer	Business Phone No	
Subscriber's Name:	Subsriber's Birthdate:	
Dental Insurance	Dental Ins. Phone	
Group # or Plan #	_ Subscriber ID#	
Person Responsible for Bill	Birthdate	
Relationship to you	Soc.Sec.No	
Billing Address	Phone No	
Dental Insurance	Group No. or Plan No	

Whom may we thank for referring you to us?_____

APPOINTMENTS: We work by appointment only so your wait will be minimal and your treatment done efficiently. To help us serve you better we ask for 2 business days notice for changes in your appointment.

INSURANCE: To avoid misunderstanding regarding dental insurance, we want our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

SIGNATURE_

(Parent or Guardian's signature)

First Name Middle Initial Last Name Month Day Year	Patient's Name	Date of Birth
Please check any of the following your child ever had: □ Teeth sensitive to cold, heat, sweets, etc. □ Bleeding gums, How Long?		Month Day Year
Please check any of the following your child ever had: □ Teeth sensitive to cold, heat, sweets, etc. □ Bleeding gums, How Long?	DENTAL HISTORY	
Bleeding gums, How Long? Food impaction Clenching or grinding Burning of torgue Swelling or lumps in mouth Frequent bilsters on lips or mouth Pain around ears Cilcking or popping in ear while eating Bad Breath Unpleasant taste Complications from extractions Periodontal treatment Orthodontic treatment (braces) Mouth breathing Tongue thurst Ortal habits, i.e. finger nail biting, cheek biting, ect. Thumb sucking Please check any of the following your child uses: Dental floss Inter dental stimulators Water jet device Disclosing tablets or solutions Fluoride supplements Tooth brush, frequency of brushing? Allergies to drugs WHICH? Extrements Allergies to drugs WHICH? Malinancies (cancer) Any heart ailments Stroke Excessive bleeding from cut or extraction Arthritis Arthritis Asthma Athritis Asthma Tuberculosis User or other allergies User or colter allergies Diabetes Athritis Athriti		
Clenching or grinding Clenching or grinding Clenching or grinding Clenching or lumps in mouth Frequent bisters on lips or mouth Frequent bisters on lips or mouth Clicking or popping in ear while eating Clicking or popping in ear while eating Complications from extractions Complications frequency of brushing? Complications frequency of the following? Complications frequency frequency Complications frequency Complications frequency Complications frequency Complications frequency Complications Co		
Burning of torque Burning of the following your child uses: Burning of the following your child uses: Burning of the following your child uses: Burning of torque Burning of the following your child uses:	Food impaction	
Swelling or lumps in mouth Frequent blisters on lips or mouth Pain around ears Citcking or popping in ear while eating Bad Breath Unpleasant taste Complications from extractions Periodontal treatment Orthodonic treatment (traces) Mouth breathing Tongue thurst Oral habits, i.e. finger nail biting, cheek biting, ect. Thumb sucking Please check any of the following your child uses: Dental floss Inter dental stimulators Water jet device Disclosing tablets or solutions Fluoride supplements Tooth brush, frequency of brushing? Allergies to anesthetics WHICH? Allergies to anesthetics WHICH? Allergies to anesthetics WHICH? Neurological problems Radiation treatments Excessive bleeding from cut or extraction Any heart ailments Excessive bleeding from cut or extraction Anstma Diabetes Arthritis Arthritis Arthritis Diabetes Veneral disease	Clenching or grinding	
Frequent bilisters on lips or mouth Pain around ears Clicking or popping in ear while eating Bad Breath Unpleasant taste Complications from extractions Periodontal treatment Orthodontic treatment (braces) Mouth breathing Tongue thurst Oral habits, i.e. finger nail biting, cheek biting, ect. Thumb sucking Please check any of the following your child uses: Dental floss Inter dental stimulators Water jet device Disclosing tablets or solutions Fluoride supplements Tongue torust Torth brush, frequency of brushing? MEDICAL HISTORY Has your child had any of the following? Allergies to anesthetics WHICH? Allergies to drugs WHICH? Neurological problems Radiation treatments Stroke Stroke Any heart aliments Stroke Athritis Anthritis Athritis Athriti		
Pain around ears Clicking or popping in ear while eating Bad Breath Unpleasant taste Complications from extractions Periodontal treatment Orthodontic treatment (braces) Mouth breathing Tongue thurst Oral habits, i.e. finger nail biting, cheek biting, ect. Thumb sucking Please check any of the following your child uses: Dental floss Dental floss Dental floss Dental floss Disclosing tablets or solutions Fluoride supplements Tooth brush, frequency of brushing? Allergies to drugs WHICH? Allergies to anesthetics WHICH? Any heart aliments Radiation treatments Radiation treatments Excessive bleeding from cut or extraction Any heart aliments Excessive bleeding from cut or extraction Anthrits Anthma Anemia or blood problems Excessive bleeding from cut or extraction Anthrits Athma Diabetes Veneral disease Diabetes Veneral disease Diabetes Veneral disease Date of last physical exam Pharmacy of Choice: Physician's Name If so, why? Clicking results		
Clicking or popping in ear while eating Bad Breath Uppleasant taste Complications from extractions Periodontal treatment Orthodontic treatment (braces) Mouth breathing Tongue thurst Oral habits, i.e. finger nail biting, cheek biting, ect. Thumb sucking Please check any of the following your child uses: Dental floss Inter dental stimulators Water jet device Disclosing tablets or solutions Fluoride supplements Tooth brush, frequency of brushing? Liver problems or hepatitis Allergies to drugs WHICH? Allergies to drugs WHICH? Allergies to drugs WHICH? Meurological problems Hadinancies (cancer) Any heart ailments Radiation treatments Stoke Stoke Excessive bleeding from cut or extraction Thyroid problems Eye disorders Anthritis Anthritis Toositis Extende Athritis Conter allergies Ucer of other allergies Ucer of other allergies Veneral disease Physician's Name Date of last physical exam_ Physician's Name If so, why?		
Bad Breath Unpleasant taste Complications from extractions Periodontal treatment Orthodontic treatment (braces) Mouth breathing Tongue thurst Oral habits, i.e. finger nail bitting, cheek bitting, ect. Thumb sucking Please check any of the following your child uses: Dental floss Inter dental stimulators Water jet device Disclosing tablets or solutions Fluoride supplements Tooth brush, frequency of brushing? Allergies to drugs WHICH? Allergies to anesthetics WHICH? Allergies to anesthetics WHICH? Allergies to anesthetics WHICH? Allergies to anesthetics WHICH? Neurological problems Radiation treatments Radiation treatments Radiation treatments Athritis Anemia or blood problems Athritis Tonsilitis Tonsilitis Diabetes Veneral disease Veneral disease Veneral disease Veneral disease Veneral disease <tr< td=""><td></td><td></td></tr<>		
Unpleasant taste Complications from extractions Periodontal treatment Orthodontic treatment (braces) Mouth breathing Tongue thurst Oral habits, i.e. finger nail biting, cheek biting, ect. Thumb sucking Please check any of the following your child uses: Dental floss Inter dental stimulators Water jet device Disclosing tablets or solutions Fluoride supplements Tooth brush, frequency of brushing? MEDICAL HISTORY Allergies to drugs WHICH? Allergies to drugs WHICH? Allergies to drugs WHICH? Mainancies (cancer) Allergies to drugs WHICH? Mainancies (cancer) Allergies to anesthetics WHICH? Mainancies (cancer) Allergies to drugs WHICH? Detart aliments Bruchod problems Sinus problems Sinus problems Sinus problems Anemia or blood problems Arthritis Anthritis Diabetes Veneral disease Veneral disease Date of last physical exam Physician's Name Date of last physical exam If so, why?		
Complications from extractions Periodontal treatment Conhodonit creatment (braces) Mouth breathing Tongue thurst Oral habits, i.e. finger nail biting, cheek biting, ect. Thumb sucking Please check any of the following your child uses: Dental floss Inter dental stimulators Utate jet device Disclosing tablets or solutions Fluoride supplements Tooth brush, frequency of brushing? Allergies to drugs WHICH? Allergies to aresthetics WHICH? Allergies to drugs WHICH? Recological problems Radiation treatments Radiation treatments Athinis Asthma Asthma Utate of the allergies Ucer of other allergies Ucer of other allergies Date of last physical exam Pharmacy of Choice: Syour child presently under a physician's care? If so, why? Complex care care care care care care care care		
Periodontal treatment Orthodontic treatment (braces) Mouth breathing Tongue thurst Oral habits, i.e. finger nail biting, cheek biting, ect. Thumb sucking Please check any of the following your child uses: Dental floss Inter dental stimulators Water jet device Disclosing tablets or solutions Fluoride supplements Tooth brush, frequency of brushing? MEDICAL HISTORY Allergies to drugs WHICH? Allergies to drugs WHICH? Allergies to drugs WHICH? Metric fever Radiation treatments Stroke Excessive bleeding from cut or extraction Anemia or blood problems Excessive bleeding from cut or extraction Hay fever or other allergies Usereal disease Veneral disease Date of last physical exam Physician's Name Date of last physical exam If so, why?	•	
Orthodontic treatment (braces) Mouth breathing Oral habits, i.e. finger nail biting, cheek biting, ect. Thumb sucking Please check any of the following your child uses: Dental floss Inter dental stimulators Water jet device Disclosing tablets or solutions Fluoride supplements Tooth brush, frequency of brushing? Allergies to anosthetics WHICH? Any heart ailments Any heart ailments Rediation treatments Radiation treatments Athritis Arthritis Asthma Athritis Asthma Athritis Asthma Athritis Asthma Athritis Disclosese Disclosese Disclosese Disclosesese Disclosesesese Disclosesese Disclosesesese Disclosesese Disclosesesese Disclosesesesesesesesesesesesesesesesesesese		
Mouth breathing Tongue thurst Oral habits, i.e. finger nail biting, cheek biting, ect. Thumb sucking Please check any of the following your child uses: Dental floss Inter dental stimulators Water jet device Disclosing tablets or solutions Fluoride supplements Tooth brush, frequency of brushing? Allergies to drugs WHICH? Allergies to anesthetics WHICH? Syncr child pressure Any heart ailments Stroke Excessive bleeding from cut or extraction Anemia or blood problems Athritis Auter of the follewing Veneral disease Syndrome Date of last physical exam Phone # s your child presently under a physician's care? If so, why?		
Tongue thurst Oral habits, i.e. finger nail biting, cheek biting, ect. Thumb sucking Please check any of the following your child uses: Inter dental stimulators Water jet device Disclosing tablets or solutions Fluoride supplements Tooth brush, frequency of brushing? MEDICAL HISTORY MEDICAL HISTORY MEDICAL HISTORY MEDICAL HISTORY Inter dental imments Disclosing tablets or solutions? Allergies to anesthetics WHICH? Allergies to anesthetics WHICH? Any heart aliments Any heart aliments Radiation treatments Sinus problems Arthritis Anthria Athrna Dicd problems Athrna Ulcer of the following Ulcer of colitis Diabetes Veneral disease Drug or Alcohol dependency Acquired Immune Defiency Syndrome Acqui		
Oral habits, i.e. finger nail biting, cheek biting, ect. Thumb sucking Please check any of the following your child uses: Dental floss Dental floss Dental floss Disclosing tablets or solutions Fluoride supplements Tooth brush, frequency of brushing? MEDICAL HISTORY MEDICAL HISTORY MEDICAL HISTORY Malinancies (cancer) Allergies to drugs WHICH? Allergies to drugs WHICH? Allergies to drugs WHICH? Allergies to anesthetics WHICH? Allergies to anesthetics WHICH? Allergies to anesthetics WHICH? Allergies to anesthetics WHICH? Allergies to drugs the following? Allergies to anesthetics which are approximately and the following of the following? Allergies to anesthetics which are approximately and the following of the following of the following of the following of the following? Allergies to anesthetics which are approximately and the analysis of the following of the following? Allergies to drugs WHICH? Allergies to anesthetics which are approximately and the analysis of the following of the followin		
Thumb sucking Thumb sucking Please check any of the following your child uses: Dental floss Inter dental stimulators Disclosing tablets or solutions Fluoride supplements Tooth brush, frequency of brushing? MEDICAL HISTORY Has your child had any of the following? Allergies to drugs WHICH? Allergies to drugs WHICH? Allergies to drugs WHICH? Allergies to drugs WHICH? Any heart ailments High blood pressure Neurological problems Radiation treatments Anemia or blood problems Anemia or blood problems Anthritis Asthma Tuberculosis Hay fever or other allergies Ulcer of colitis Diabetes Veneral disease Veneral disease Carcenter Date of last physical exam Physician's Name Physician's Name Syour child presently under a physician's care? Is your child presently under a phys		
Dental floss Inter dental stimulators Water jet device Disclosing tablets or solutions Fluoride supplements Tooth brush, frequency of brushing? MEDICAL HISTORY Has your child had any of the following? Allergies to drugs WHICH? Allergies to anesthetics WHICH? Allergies to anesthetics WHICH? Any heart aliments High blood pressure High blood pressure Radiation treatments Struke Struke Struke Struke Construktion Anemia or blood problems Arthritis Hay fever or other allergies Ucer of colitis Diabetes Veneral disease Physician's Name Date of last physical exam Phone # paramacy of Choice: Phone #		
Dental floss Inter dental stimulators Water jet device Disclosing tablets or solutions Fluoride supplements Tooth brush, frequency of brushing?	lease check any of the following your child uses:	
Water jet device Disclosing tablets or solutions Fluoride supplements Tooth brush, frequency of brushing? MEDICAL HISTORY tas your child had any of the following? Allergies to drugs WHICH? Liver problems or hepatitis Allergies to anesthetics WHICH? Malinancies (cancer) Any heart ailments Psychiatric care/emotional problems High blood pressure Rheumatic fever Neurological problems Sinus problems Radiation treatments Stroke Excessive bleeding from cut or extraction Thyroid problems Asthma Tuberculosis Hay fever or other allergies Ulcer of colitis Diabetes Drug or Alcohol dependency Acquired Immune Defiency Syndrome Epilepsy whysician's Name Date of last physical exam wharmacy of Choice: Phone # way or child presently under a physician's care? If so, why?		
Disclosing tablets or solutions Fluoride supplements Tooth brush, frequency of brushing?	Inter dental stimulators	
Fluoride supplements Tooth brush, frequency of brushing?		
Tooth brush, frequency of brushing?		
MEDICAL HISTORY thas your child had any of the following? Allergies to drugs WHICH? Allergies to anesthetics WHICH? Any heart ailments High blood pressure Neurological problems Radiation treatments Excessive bleeding from cut or extraction Anthritis Athrma Athrma Tuberculosis Ulcer of colitis Diabetes Veneral disease Veneral disease Acquired Immune Defiency Syndrome Physician's Name Pharmacy of Choice: Pharmacy of Choice: Image: Image: Image: Image: Image: Image: Image: Medication from the applican's care? Image: Image		
Has your child had any of the following? Allergies to drugs WHICH? Allergies to anesthetics WHICH? Any heart ailments High blood pressure Radiation treatments Stroke Excessive bleeding from cut or extraction Anthritis Asthma Tuber of colitis Hay fever or other allergies Ulcer of colitis Veneral disease Veneral disease Drug or Alcohol dependency Acquired Immune Defiency Syndrome Pharmacy of Choice: Phone # If so, why?	\Box rooth brush, frequency of brushing?	
 Allergies to drugs WHICH? Allergies to anesthetics WHICH? Any heart ailments High blood pressure Neurological problems Radiation treatments Radiation treatments Stroke Excessive bleeding from cut or extraction Anemia or blood problems Asthma Tuberculosis Hay fever or other allergies Veneral disease Acquired Immune Defiency Syndrome Pharmacy of Choice: Phone # If so, why? 	MEDICAL HISTORY	
 Allergies to anesthetics WHICH? Any heart ailments High blood pressure Neurological problems Radiation treatments Stroke Excessive bleeding from cut or extraction Anemia or blood problems Anemia or blood problems Arthritis Asthma Tuberculosis Ulcer of colitis Diabetes Veneral disease Veneral disease Veneral disease Veneral disease Veneral disease Acquired Immune Defiency Syndrome Physician's Name Date of last physical exam Phone # If so, why? 	las your child had any of the following?	
 Any heart ailments High blood pressure Neurological problems Radiation treatments Excessive bleeding from cut or extraction Anemia or blood problems Arthritis Asthma Tuberculosis Ulcer of colitis Diabetes Veneral disease Veneral disease Veneral disease Veneral disease Acquired Immune Defiency Syndrome Date of last physical exam Phone # Syour child presently under a physician's care? If so, why? 	Allergies to drugs WHICH?	Liver problems or hepatitis
 High blood pressure Neurological problems Radiation treatments Excessive bleeding from cut or extraction Anemia or blood problems Anemia or blood problems Arthritis Asthma Tuberculosis Ulcer of colitis Diabetes Veneral disease Veneral disease Veneral disease Acquired Immune Defiency Syndrome Physician's Name Date of last physical exam Phone # s your child presently under a physician's care? If so, why? 	Allergies to anesthetics WHICH?	Malinancies (cancer)
 Neurological problems Radiation treatments Excessive bleeding from cut or extraction Anemia or blood problems Arthritis Asthma Tuberculosis Ulcer of colitis Diabetes Veneral disease Veneral disease Acquired Immune Defiency Syndrome Physician's Name Date of last physical exam Phone # 	Any heart ailments	Psychiatric care/emotional problems
Radiation treatments Stroke Excessive bleeding from cut or extraction Thyroid problems Anemia or blood problems Eye disorders Arthritis Tonsilitis Asthma Tuberculosis Hay fever or other allergies Ulcer of colitis Diabetes Kidney problems Veneral disease Drug or Alcohol dependency Acquired Immune Defiency Syndrome Epilepsy Pharmacy of Choice: Phone # way or child presently under a physician's care? If so, why?	High blood pressure	Rheumatic fever
 Excessive bleeding from cut or extraction Anemia or blood problems Arthritis Asthma Tuberculosis Hay fever or other allergies Diabetes Veneral disease Veneral disease Acquired Immune Defiency Syndrome Epilepsy thysician's Name Date of last physical exam thysical exam thysical exam thermacy of Choice: Phone # If so, why?	Neurological problems	Sinus problems
 Anemia or blood problems Arthritis Asthma Tuberculosis Hay fever or other allergies Diabetes Veneral disease Veneral disease Acquired Immune Defiency Syndrome Epilepsy Physician's Name Date of last physical exam Phone # Syour child presently under a physician's care? If so, why? 	Radiation treatments	□ Stroke
 Arthritis Asthma Tuberculosis Tuberculosis Ulcer of colitis Diabetes Veneral disease Veneral disease Acquired Immune Defiency Syndrome Acquired Immune Defiency Syndrome Date of last physical exam Phone # syour child presently under a physician's care? If so, why? 	Excessive bleeding from cut or extraction	Thyroid problems
 Asthma Hay fever or other allergies Diabetes Veneral disease Acquired Immune Defiency Syndrome Acquired Immune Defiency Syndrome Date of last physical exam harmacy of Choice: Phone # your child presently under a physician's care? If so, why? 	Anemia or blood problems	Eye disorders
 Hay fever or other allergies Diabetes Veneral disease Acquired Immune Defiency Syndrome Hay fever or other allergies Ulcer of colitis Kidney problems Drug or Alcohol dependency Epilepsy hysician's Name Date of last physical exam harmacy of Choice: Phone # your child presently under a physician's care? If so, why?	Arthritis	Tonsilitis
 Diabetes Veneral disease Acquired Immune Defiency Syndrome Acquired Immune Defiency Syndrome Epilepsy Date of last physical exam harmacy of Choice: Phone # your child presently under a physician's care? If so, why? 	Asthma	Tuberculosis
 Diabetes Veneral disease Acquired Immune Defiency Syndrome Acquired Immune Defiency Syndrome Epilepsy Date of last physical exam harmacy of Choice: Phone # your child presently under a physician's care? If so, why? 	Hay fever or other allergies	Ulcer of colitis
 Veneral disease Acquired Immune Defiency Syndrome bysician's Name Date of last physical exam Date of last physical exam Phone # syour child presently under a physician's care? If so, why? 		Kidney problems
Acquired Immune Defiency Syndrome Epilepsy Physician's Name Date of last physical exam Pharmacy of Choice: Phone # s your child presently under a physician's care? If so, why?	Veneral disease	
Pharmacy of Choice: Phone # Phone #s your child presently under a physician's care? If so, why?	Acquired Immune Defiency Syndrome	
s your child presently under a physician's care? If so, why?	hysician's Name	_ Date of last physical exam
	Pharmacy of Choice:	Phone #
····, ····, ·······		

Date of Birth_

(Parent of Guardian's Signature)

Patient's Name_