Health History & Acquaintance Form **Date: _____**

Name: _____, _____ ____ _____
Last First MI I prefer to be called

Email: _____ DL#_____

Birth Date: _____/_____/_____ Social Security#: _____-_____-_____ Marital status: S M

Home address: _____City:_____ State: _____ Zip: _____

Home #: (_____) -_____ -_____Cell #: (_____) - _____ - _____Work # (_____) - _____ - _____ Ext: _____

Employed by: _____

Address: _____ City: _____ State: _____ Zip:_____

Occupation: _____How long? _____

Who may we thank for referring you? _____

Responsible Party: _____ Best time for you: M T W R AM/PM

Emergency Contact: _____ Relationship: _____ Phone #: (_____) - _____ - _____

Insurance Information

Ins. Cpy: _____ Ins. Phone #: _____ Policy ID #:_____

Subscribers Name: _____ Relationship: _____ Employer: _____

Subscribers Birth Date: _____/_____/_____ Social Security#: _____-_____-_____

Dental History

Previous Dentist: _____ When was your last dental visit? _____
Are you having any dental problems presently? Y N Describe: _____
_____

Have you ever had gum treatment? Y N Do your gums ever bleed? Y N
Have you ever had orthodontics (braces)? Y N Do you grind / clench your teeth when you are nervous or sleeping? Y N
Do your jaws click or pop when you chew? Y N Have you ever been treated for TMJ (jaw) problems? Y N
Would you like fresher breath? Y N Are you interested in cosmetic dentistry (bleaching, etc.)? Y N

Medical History

Physician name: _____ Tel #_____ Date of last visit: ____/____/_____

Your current physical health is: Excellent Good Poor Are you taking any medications? Y N

If yes, please list: _____

Are you required to take any medication before your dental appointment? Y N _____

Has there been a change in your health in the last year? Y N Explain: _____

_____