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____ City____________________________ Zip_____________

Father's Name____ Soc.Sec.No.____________________________________

Birthdate____ Home Phone No.________________________________

e-mail Address____ Cell No.____

Home Address____ City___________________________ Zip_____________

Employer____ Business Phone No._____________________________

Dental Insurance_______________________________________ Dental Ins. Phone_______________________________

Group No or Plan No.___________________________________ Subscriber ID#__________________________________

Mother's Name____ Soc.Sec.No.____________________________________

Birthdate____ Home Phone No.________________________________

e-mail Address____ Cell No.____

Home Address____ City____________________________ Zip_____________

Employer____ Business Phone No._____________________________

Dental Insurance_______________________________________ Dental Ins. Phone_______________________________

Group No or Plan No.___________________________________ 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?____

My Pharmacy of Choice: ____ **Phone #** __________________________

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. Not showing or canceling same day may result in a fee and possible loss of future appointment privileges.

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_______________________________________ **DATE**___________________________
(Parent or Guardian's signature)

PLEASE TURN OVER AND COMPLETE OTHER SIDE. THANK YOU.

Patient's Name____ **Date of Birth**__________________________
First Name Middle Initial Last Name Month Day Year

DENTAL HISTORY
Please check any of the following your child ever had:

- ☐ Teeth sensitive to cold, heat, sweets, etc.
- ☐ Bleeding gums, How Long?___________
- ☐ Food impaction
- ☐ Clenching or grinding
- ☐ Burning of tongue
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters 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
- ☐ Tooth brush, frequency of brushing? ______________________________

MEDICAL HISTORY
Has 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
- ☐ Anemia or blood problems
- ☐ Arthritis
- ☐ Asthma
- ☐ Hay fever or other allergies
- ☐ Diabetes
- ☐ Veneral disease
- ☐ Acquired Immune Defiency Syndrome
- ☐ Liver problems or hepatitis
- ☐ Malinancies (cancer)
- ☐ Psychiatric care/emotional problems
- ☐ Rheumatic fever
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Eye disorders
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcer of colitis
- ☐ Kidney problems
- ☐ Drug or Alcohol dependency
- ☐ Epilepsy

Physician's Name___________________________________ Date of last physical exam_______________________

Is your child presently under a physician's care? __________ If so, why? ____________________________________

Is your child presently taking any medications? ___________ If so, why? ____________________________________

SIGNATURE______________________________________ (Parent or Guardian's Signature)