

PATIENT ACQUAINTANCE FORM

Date: _____		
Patient Name: _____ M F I prefer to be called: _____		
(First, Last, Middle Initial)		
Address: _____	Birth Date: _____	SSN: _____
_____	Home Phone: _____	_____
Email Address: _____	Work Phone: _____	_____
What is the best way to reach you? _____	Cell Phone: _____	_____
<i>Person Responsible for Account:</i>		
Name: _____	Home Phone: _____	_____
Address: _____	Work Phone: _____	_____
_____	SSN: _____	_____
Who should we contact in case of an emergency:		
Name: _____	Phone: _____	_____
Who can we thank for referring you to our office?		

MEDICAL HISTORY:

- Physician's name: _____ City: _____ Phone: _____
- Have you taken cortico steroids and/or blood thinners including aspirin recently and for how long? ____ Yes ____ No If yes, please explain: _____
- Are you taking any medication, herbal supplements, or drugs now? ____ Yes ____ No
- If so, please list: _____

Are you sensitive (allergic) to any drugs or anesthetics?

____ Penicillin ____ Aspirin ____ Codeine ____ Sulfa ____ Novocaine
 ____ Other _____

Please indicate which of the following you have had or presently have (check all that apply)

- | | | |
|---|---|---|
| <ul style="list-style-type: none"> <input type="radio"/> Heart Surgery/Disease/Attack <input type="radio"/> Diabetes <input type="radio"/> Congenital Heart Disease <input type="radio"/> Blood Transfusion <input type="radio"/> Heart Murmur <input type="radio"/> Asthma <input type="radio"/> Sinus Trouble <input type="radio"/> Fainting or Dizzy Spells <input type="radio"/> Drug or alcohol Abuse <input type="radio"/> Nervousness/Anxiety <input type="radio"/> Ulcers <input type="radio"/> Immunocompromised Disease <input type="radio"/> Venereal Disease <input type="radio"/> Thyroid Problems | <ul style="list-style-type: none"> <input type="radio"/> Mitral Valve Prolapse <input type="radio"/> Artificial Heart Valve <input type="radio"/> Tuberculosis <input type="radio"/> Hay Fever <input type="radio"/> Epilepsy or Seizures <input type="radio"/> Artificial Joint <input type="radio"/> Tumors <input type="radio"/> Low Blood Pressure <input type="radio"/> Hepatitis A (infectious) B (serum) <input type="radio"/> High Blood Pressure <input type="radio"/> Emphysema <input type="radio"/> Hemophilia <input type="radio"/> Rheumatic Fever <input type="radio"/> Latex Sensitivity <input type="radio"/> Radiation Therapy | <ul style="list-style-type: none"> <input type="radio"/> Chemotherapy <input type="radio"/> Psychiatric Care <input type="radio"/> High Cholesterol <input type="radio"/> Persistant Cough for 3 weeks or longer <input type="radio"/> Weight Loss <input type="radio"/> Fever/Night Sweats <input type="radio"/> Coughing up Blood <input type="radio"/> Chest Pain <input type="radio"/> Hoarseness <input type="radio"/> Swollen lymph nodes <input type="radio"/> Cold Sores/Fever Blisters <input type="radio"/> Other _____ |
|---|---|---|

Women: Are you: Pregnant: ____ Yes ____ No Nursing? ____ Yes ____ No Taking Birth Control Pills ____ Yes ____ No

I understand the above information is necessary to provide me with dental care in a safe and effective manner. I have answered the questions to the best of my knowledge. I understand I am responsible for all cost of dental treatment. I hereby authorize this office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

- Pursuant to Virginia Law 32.1-45.1 – Any patient who exposes a health care provider or his employee/agent to body fluid in a manner which may transmit the human immunodeficiency virus (HIV), Hepatitis B or C virus is deemed to have consented to HIV, Hepatitis B and C testing and disclosure of the results to the person exposed. This deemed consent also applies to a health care provider who exposes a patient to body fluid in the above stated manner.

Signature: _____
 Patient, Parent or Guardian

Date: _____