For Office Use Only
Patient ID:_____
Ins. ID:_____

Fax securely to 210.680.4184

Acquaintance Form

Name_____ Preferred to be called_____

Address_____

Employer_____ Occupation_____

Home Tele._____ Bus. Tele._____ Soc. Sec. #_____

Cell Tele._____ Email Address_____

Birthdate_____ DL#_____ Marital Status: S☐ M☐ D☐ S☐

How did you hear about us?_____

Person Responsible For Payment Of Account

Name_____ Relationship to patient_____

Address_____

Employer_____ Occupation_____

Business Address_____

Home Tele._____ Bus. Tele._____ Ext._____

Birthdate_____ Sex____ Soc. Sec. #_____

Dental Insurance Information

Primary Insurance Company_____ Employer_____

Subscribers Name_____ Soc. Sec. #_____

Group Number_____ Union or Local Number_____

Employees Relationship to Subscriber- Self☐ Spouse☐ Child☐

I authorize the release of any information necessary to process my insurance claim and hereby authorize payment to the dentist all insurance benefits otherwise payable to me **I understand that if any insurance does not pay, I am financially responsible for the full amount.** The full amount is due after notice has been issued. A copy of this signature is as valid as the original.

X_____ Date_____

General Health History

Are you in good health?..... ☐ YES ☐ NO

If no, please explain:_____

Are you under a physician's care now?..... ☐ YES ☐ NO

If yes, please explain:_____

Name of physician_____ City_____

Are you currently taking any drugs or medications?..... ☐ YES ☐ NO

If yes, please list:_____

Are you sensitive or allergic to any drugs?..... ☐ YES ☐ NO

If yes, please list?_____

Have you been hospitalized in the past two years?..... ☐ YES ☐ NO

If yes, please explain_____

Do you now have or have you had any of the following?

	YES	NO		YES	NO
A.I.D.S	☐	☐	Herpes	☐	☐
Allergies	☐	☐	Hepatitis	☐	☐
Anemia	☐	☐	High Blood Pressure	☐	☐
Asthma or Hay Fever	☐	☐	Kidney Disease	☐	☐
Blood Diseases	☐	☐	Liver Disease	☐	☐
Cancer	☐	☐	Radiation Treatment	☐	☐
Diabetes	☐	☐	Rheumatic Fever	☐	☐
Epilepsy	☐	☐	Rheumatism or Arthritis	☐	☐
Excessive Bleeding	☐	☐	Stroke	☐	☐
Fainting Spells or Seizures	☐	☐	Stomach Ulcers	☐	☐
Heart Disease	☐	☐	Tuberculosis	☐	☐
Heart Murmur	☐	☐	Venereal Disease	☐	☐

Do you have any disease, condition, or problem not listed?..... ☐ YES ☐ NO

WOMEN: Are you pregnant?..... ☐ YES ☐ NO

If yes, when is your due date?_____

Are you taking, or do you have, birth control?..... ☐ YES ☐ NO

Dental History

Dental Complaint at this moment:_____

Date of your last dental treatment ____/____/____ Last Cleaning ____/____/____

Name of previous dentist:_____

	YES	NO		YES	NO
Do you grind or clench your teeth?	☐	☐	Do your gums bleed?	☐	☐
Pain in jaw point?	☐	☐	Cold or canker sores?	☐	☐
Sore or sensitive teeth?	☐	☐	Unpleasant taste?	☐	☐

The above information is true and I will notify you of any changes.

Signature_____ Date_____

In case of an emergency, contact:_____ Tele._____

Updates & Remarks:_____

_____

_____

_____