

Aquaintance Form

In this section are forms that are very important. Please take the time necessary to accurately fill them out.

We suggest this be done when you're not rushed and can candidly reveal any past fears, disappointments or problems you may have experienced in dentistry.

The more we know about you the better we'll be able to serve you.

Patient Information

			Date	19
Name Last	First	Middle	Name Friends Call You	
If Child, Give Parent's or Guardian's Name				
S.S.#	Driver's License #	Sex	Birthdate	Race
Address Street	City	State	Zip	Home Phone
Employment	Work Phone	Occupation	No. Years Employed	
Marital Status	Spouse's Name	Spouse's S.S.#	Spouse's Birth Date	
Spouse's Employment	Spouse's Work Phone	Spouse's Occupation	Spouse's No. Years Employed	
Do you have insurance that may cover any part of our professional services?		If So, Name of Company		
<input type="checkbox"/> Yes <input type="checkbox"/> No				
Highest Grade Attained in School		College		
K	1 2 3 4 5 6 7 8 9 10 11 12	1	2 3 4 5 6 7 8	+
IN CASE OF EMERGENCY, Please Notify (a person other than family member such as, co-worker, neighbor, friend, boss)				
Name			Relation	
Address			Phone	

How were you referred to our office?

I, THE UNDERSIGNED (PATIENT OR LEGALLY RESPONSIBLE PARTY). (A) CERTIFY THAT THE INFORMATION GIVEN ON THIS FORM IS TRUE AND CORRECT; (B) AUTHORIZE DENTAL TREATMENT TO BE RENDERED BY THE DENTIST AND HIS STAFF; (C) UNDERSTAND AND ACCEPT THAT I WILL BE RESPONSIBLE FOR PAYMENT OF THIS TOTAL FEE REGARDLESS OF MY DENTAL INSURANCE BENEFITS.

SIGNATURE

DATE

Medical Questionnaire

Correct answers to the following questions will allow Dr. Scott to treat you so there **will not** be an emergency. However, if an emergency situation does arise this information will help insure proper treatment. As before, your answers are for our records only and will be considered confidential.

Are you being treated by a Medical Doctor now?		If Yes, for what reason?
1. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you taking any drugs or medicine at the present time?		What?
2. <input type="checkbox"/> Yes <input type="checkbox"/> No FOR?		
Medical Doctors Name	Date of Last Exam	If child - approximate weight/height.
3. Are you sensitive or allergic to any medicine, including penicillin?		If Yes, What, including penicillin?
4. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever been hospitalized or had any surgical operations?		If Yes, list reasons and dates.
5. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever had a blood transfusion?		If Yes, give reason and dates.
6. <input type="checkbox"/> Yes <input type="checkbox"/> No		

7. HAVE YOU HAD:	
a. ASTHMA OR HAY FEVER YES	u. GALL BLADDER DISEASE YES
b. TUBERCULOSIS YES	v. DIABETES (Sugar Disease) YES
c. RHEUMATIC FEVER, RHEUMATIC HEART DISEASE YES	w. NERVOUSNESS YES
d. SCARLET FEVER YES	x. EPILEPSY OR SEIZURES YES
e. HEART MURMUR YES	y. FAINTING OR DIZZY SPELLS YES
f. HEART DISEASE OR HEART ATTACK YES	z. GLAUCOMA YES
g. ANGINA PECTORIS YES	aa. PACEMAKER YES
h. STROKE YES	bb. THYROID DISEASE (or Goiter) YES
i. HIGH BLOOD PRESSURE YES	cc. PSYCHIATRIC TREATMENT YES
j. LOW BLOOD PRESSURE YES	dd. CHEMOTHERAPY - RADIATION THERAPY (Cancer, Leukemia) YES
k. ANEMIA YES	ee. ARE YOU PREGNANT YES
l. ALERGIES OR HIVES YES	ff. HAVE YOU EVER HAD EXCESSIVE BLEEDING FROM CUT OR WOUND? YES
m. ULCERS (Stomach or Intestinal) YES	gg. HAVE YOU HAD ANY TROUBLE OR REACTIONS TO
n. ARTHRITIS YES	LOCAL OR GENERAL ANESTHETICS? YES
o. HIV POSITIVE—AIDS YES	hh. DO YOU CLENCH OR GRIND YOUR TEETH? YES
p. HERPES SIMPLEX II YES	ii. ARE YOU DISSATISFIED WITH THE APPEARANCE OF YOUR TEETH? YES
q. VENEREAL DISEASE (i.e.; Syphilis, Gonorrhea, etc.) YES	jj. HAVE YOU EVER BEEN INSTRUCTED IN
r. KIDNEY OR BLADDER DISEASE YES	CARING FOR YOUR TEETH AND GUMS? YES
s. HEPATITIS A YES	kk. ARE YOU INTERESTED IN A PREVENTIVE DENTAL PROGRAM? YES
t. HEPATITIS B YES	ll. ARE YOU INTERESTED IN COSMETIC DENTISTRY? YES

IN CASE OF EMERGENCY, Please Notify (a person other than family member such as, co-worker, neighbor, friend, boss)

Name	Relation
Address	Phone

Dental Questionnaire

Correct answers to the following questions will allow Dr. Scott to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. When was your last dental appointment? _____
2. Do you want to learn to control dental disease and retain your teeth? Yes No
3. Does dental treatment make you nervous? No Slightly Moderately Extremely
4. Do you get frustrated because you always have something to be treated or repaired when you visit the dentist? Yes No
5. Are you deeply concerned about finances required to return your mouth to excellent dental health? Yes No
6. Are you dissatisfied with your teeth and their appearance? Yes No
7. Have you ever had any serious trouble associated with previous dentistry? Yes No
8. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? Yes No
9. Are you having any discomfort at this time? Yes No
10. How often do you brush? _____ Brush is: Soft Medium Hard

11. Do you have or have you ever had any of the following:

TEETH

- | | | |
|------------------------------|------------------------------|-----------------------------|
| Loose teeth | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sensitivity to hot | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sensitivity to cold | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sensitivity to sweets | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sensitive to biting pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Food impaction areas | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Clenching/grinding | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If so, when _____ | | |
| Shifting in bite | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Change in bite | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

MOUTH

- | | | |
|------------------------------------|------------------------------|-----------------------------|
| Bleeding, sore gums | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Unpleasant taste/bad breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Burning tongue/lips | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Frequent fever blister, lips/mouth | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Swelling/lumps around teeth | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Swelling/lumps in mouth | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ortho treatments (braces) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Biting cheeks/lips | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Clicking/popping jaw | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Difficulty opening or closing jaw | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

12. Do you use the following:

- | | | |
|---------------------------------|------------------------------|-----------------------------|
| Pre-Brushing rinse (Plax) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Brush | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| How often? _____ | | |
| Dental floss | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| How often? _____ | | |

- | | | |
|-------------------------------------------------------------------|------------------------------|-----------------------------|
| Fluoride Rinse | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Waterpic | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Rotodent, Interplak, Brawn Oral B Plaque Remover }
Other _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

These are the things that are important to me about my dental health: _____

What do you fear most about dental care? _____

Circle one:

- | | |
|-------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. My mouth is | a) very comfortable.
b) moderately comfortable
c) uncomfortable. |
| 2. I | a) think the appearance of my mouth is excellent.
b) am satisfied with the appearance of my mouth.
c) am dissatisfied with the appearance of my mouth. |
| 3. I | a) will do anything to keep my natural teeth.
b) want to keep my teeth, but have a certain budget of time and money I am willing to spend on them.
c) don't care whether I keep my teeth or not. |
| 4. I | a) have set goals for my oral health with a previous dentist.
b) want to set goals concerning my dental health.
c) never set goals concerning my dental health. |
| 5. I | a) have always done the best that was recommended for my dental health.
b) have not done what dentists have recommended for my mouth.
c) rarely go, and don't care much about having my dental work completed. |
| 6. I have | a) put dentistry for myself and my family high on my priority list.
b) put dentistry for myself and my family low on my priority list.
c) it on my list but it is hard to find. |
| 7. I think my present state of dental health is | a) excellent.
b) good.
c) poor. |
| 8. I aspire to a mouth with: | a) excellent health.
b) good health.
c) poor health. |

9. What are some questions about dentistry and oral health that you have never had adequately answered for you? _____

Please complete the following if you have dental insurance. The information below is not necessary for us to provide the quality dental care that you value, but is necessary so that we might help you with your dental insurance. This is a service we provide, but is not our responsibility. Please be thorough and complete so your dental insurance might be maximized for your personal benefit.

Dental Insurance Information

Insured's Name Last		First	Middle	Insured's S.S.#	Insured's Date of Birth
Dental Insurance Company			Group No.	Local No.	
Dental Insurance Company Address Street		City	State	Zip	
Insured's Employer		Employer's Address			Phone
Date of Marriage	Date of Employment		Effective Date of Dental Insurance	Calendar Year of Insurance	

Do you have dual coverage? (Are you also covered by another insurance plan?)

Yes No If Yes complete the following:

Insured's Name Last		First	Middle	Insured's S.S.#
Dental Insurance Company			Group No.	Local No.
Dental Insurance Company Address Street		City	State	Zip
Insured's Employer		Employer's Address		
Date of Employment		Effective Date of Dental Insurance		Calendar Year of Insurance

FOR OFFICE USE ONLY

Deductible _____

Maximum _____

Preventive _____

Basic _____

Major _____

Other _____