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

	Cell Phone	E-Mail:	Date	20
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? ☐ Yes ☐ No

If So, Name of Company

Highest Grade Attained in School

K 1 2 3 4 5 6 7 8 9 10 11 12

College

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

7. HAVE YOU HAD:

a. ASTHMA OR HAY FEVER ..... YES
b. TUBERCULOSIS ..... YES
c. RHEUMATIC FEVER, RHEUMATIC HEART DISEASE ..... YES
d. SCARLET FEVER ..... YES
e. HEART MURMUR ..... YES
f. HEART DISEASE OR HEART ATTACK ..... YES
g. ANGINA PECTORIS ..... YES
h. STROKE ..... YES
i. HIGH BLOOD PRESSURE ..... YES
j. LOW BLOOD PRESSURE ..... YES
k. ANEMIA ..... YES
l. ALERGIES OR HIVES ..... YES
m. ULCERS (Stomach or Intestinal) ..... YES
n. ARTHRITIS ..... YES
o. **HIV POSITIVE—AIDS** ..... YES
p. HERPES SIMPLEX II ..... YES
q. VENEREAL DISEASE (i.e.; Syphilis, Gonorrhea, etc.) ..... YES
r. KIDNEY OR BLADDER DISEASE ..... YES
s. HEPATITIS A ..... YES
t. HEPATITIS B ..... YES
u. GALL BLADDER DISEASE ..... YES
v. DIABETES (Sugar Disease) ..... YES
w. NERVOUSNESS ..... YES
x. EPILEPSY OR SEIZURES ..... YES
y. FAINTING OR DIZZY SPELLS ..... YES
z. GLAUCOMA ..... YES
aa. PACEMAKER ..... YES
bb. THYROID DISEASE (or Goiter) ..... YES
cc. PSYCHIATRIC TREATMENT ..... YES
dd. CHEMOTHERAPY - RADIATION THERAPY (Cancer, Leukemia) ..... YES
ee. ARE YOU PREGNANT ..... YES
ff. HAVE YOU EVER HAD EXCESSIVE BLEEDING FROM CUT OR WOUND? ..... YES
gg. HAVE YOU HAD ANY TROUBLE OR REACTIONS TO LOCAL OR GENERAL ANESTHETICS? ..... YES
hh. DO YOU CLENCH OR GRIND YOUR TEETH? ..... YES
ii. ARE YOU DISSATISFIED WITH THE APPEARANCE OF YOUR TEETH? ..... YES
jj. HAVE YOU EVER BEEN INSTRUCTED IN CARING FOR YOUR TEETH AND GUMS? ..... YES
kk. ARE YOU INTERESTED IN A PREVENTIVE DENTAL PROGRAM? ..... 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			MOUTH		
Loose teeth	☐ Yes	☐ No	Bleeding, sore gums	☐ Yes	☐ No
Sensitivity to hot	☐ Yes	☐ No	Unpleasant taste/bad breath	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No	Burning tongue/lips	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No	Frequent fever blister, lips/mouth	☐ Yes	☐ No
Sensitive to biting pressure	☐ Yes	☐ No	Swelling/lumps around teeth	☐ Yes	☐ No
Food impaction areas	☐ Yes	☐ No	Swelling/lumps in mouth	☐ Yes	☐ No
Clenching/grinding	☐ Yes	☐ No	Ortho treatments (braces)	☐ Yes	☐ No
If so, when _____			Biting cheeks/lips	☐ Yes	☐ No
Shifting in bite	☐ Yes	☐ No	Clicking/popping jaw	☐ Yes	☐ No
Change in bite	☐ Yes	☐ No	Difficulty opening or closing jaw	☐ Yes	☐ No

12. Do you use the following:

Pre-Brushing rinse (Plax)	☐ Yes	☐ No	Fluoride Rinse	☐ Yes	☐ No
Brush	☐ Yes	☐ No	Waterpic	☐ Yes	☐ No
How often? _____			Rotodent, Interplak, Brawn Oral B Plaque Remover	☐ Yes	☐ No
Dental floss	☐ Yes	☐ No			
How often? _____			Other _____		

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 adequatley 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	Calender 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	Phone

Date of Employment	Effective Date of Dental Insurance	Calender Year of Insurance

FOR OFFICE USE ONLY

Deductible _____

Maximum _____

Preventive _____

Basic _____

Major _____

Other _____