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:	
*Appointment reminders are sent through e-mail or text messages. Please provide one or the other if you would like to receive appointment reminders		
Person Responsible for Account:		
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)

- ○ Heart Surgery/Disease/ Attack
- ○ Diabetes
- ○ Congenital Heart Disease
- ○ Blood Transfusion
- ○ Heart Murmur
- ○ Asthma
- ○ Sinus Trouble
- ○ Fainting or Dizzy Spells
- ○ Drug or alcohol Abuse
- ○ Nervousness/Anxiety
- ○ Ulcers
- ○ Immunocompromised Disease
- ○ Venereal Disease
- ○ Thyroid Problems
- ○ Mitral Valve Prolapse
- ○ Arificial Heart Valve
- ○ Tuberculosis
- ○ Hay Fever
- ○ Epilepsy or Seizures
- ○ Artificial Joint
- ○ Tumors
- ○ Low Blood Pressure
- ○ Hepatitis A (infectious) B (serum)
- ○ High Blood Pressure
- ○ Emphysema
- ○ Hemophilia
- ○ Rheumatic Fever
- ○ Latex Sensitivity
- ○ Radiation Therapy
- ○ Chemotherapy
- ○ Psychiatric Care
- ○ High Cholesterol
- ○ Persistant Cough for 3 weeks or longer
- ○ Weight Loss
- ○ Fever/Night Sweats
- ○ Coughing up Blood
- ○ Chest Pain
- ○ Hoarseness
- ○ Swollen lymph nodes
- ○ Cold Sores/Fever Blisters
- ○ 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: ________________________________ Date: ________________________________
Patient, Parent or Guardian