Welcome to our office. . .

GET-ACQUAINTED CARD

Patient's Name _____ Birthdate _____
Mo. Day Year

Name of Parents (*if child*) _____

Name of Spouse in Full _____

Residence Address _____

City/State/Zip _____ Phone _____

Patient Employed by _____ Occupation _____

Business Address _____ / Pat. S.S. # _____

City/State/Zip _____ Phone _____ Ext. _____

Spouse or Parent
Employed by _____ Occupation _____

Dental Insurance Co. _____ Policy Holders Soc. Sec. No. _____

Policy Holder Name _____

Referred by _____

Physician's Name _____

Date of Last Physical Examination _____ Reason _____

— PLEASE ANSWER EACH QUESTION —

	NO	YES
Poor health	❑	❑
Recent illness	❑	❑
Recent cough or cold	❑	❑
Nose obstruction	❑	❑
Heart or chest pain	❑	❑
Frequent swollen ankles	❑	❑
Facial x-ray treatment	❑	❑
Cortisone or ACTH	❑	❑
Bleeding tendency	❑	❑
Herpes	❑	❑
Hepatitis	❑	❑
Mitral Valve Prolapse	❑	❑

	NO	YES
Diabetes	❑	❑
Heart trouble	❑	❑
High Blood Pressure	❑	❑
Kidney disease	❑	❑
Liver disease	❑	❑
Lung disease	❑	❑
Asthma	❑	❑
Bronchitis	❑	❑
Rheumatic fever	❑	❑
Convulsions	❑	❑
HIV Positive	❑	❑
Artificial Limbs/Joints	❑	❑

	NO	YES
AIDS	❑	❑
Anemia	❑	❑
Allergic to:	❑	❑
Penicillin	❑	❑
Sulfa	❑	❑
Local Anesthetic	❑	❑
Codeine	❑	❑
Aspirin	❑	❑
Barbiturates	❑	❑
(sleeping pill)	❑	❑
Other drugs	❑	❑

	NO	YES
Are you pregnant?	❑	❑
Are you under the care of a physician?	❑	❑
Are you now taking medicine of any kind?	❑	❑
Have you ever responded unfavorably to medical or dental care?	❑	❑
Have you been hospitalized within the last 5 years?	❑	❑

LIST MEDICATIONS

_____
_____
_____
_____
_____

Signature _____ Date _____

HISTORY CHART Reviewed by _____ Date _____

WE RESERVE THE RIGHT TO CHARGE FOR APPOINTMENTS CANCELLED OR BROKEN WITHOUT 24 HOURS ADVANCE NOTICE.

_____
_____
_____
_____

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