Patient Acquaintance Form

Please Print: Circle One: Dr./Mr./Mrs./Ms./Miss

Last:___________________ First: _____________________Middle:________________ Jr/Sr:___

Sex: (circle) Male/Female Marital Status: (circle) Married/Single/Divorced/Widowed

Street:_________________________________City:_________________State:______ Zip:_______

Home Phone:_________________________ Cell Phone:___________________________________

Work Phone:__________________________ Employer Name:______________________________

Email Address:________________________________ May we contact you by email? **Yes/No**

Patient Social Security:_____-____-_____ Patient Date of Birth:_____/_____/_____

Emergency Contact:___________________________ Phone:_________________________

Responsible Party

Circle One: Dr./Mr./Mrs./Ms./Miss

Last:___________________ First: _____________________Middle:________________ Jr/Sr:___

Street:_________________________________City:_________________State:______ Zip:_______

Home Phone:_________________________ Cell Phone:___________________________________

Work Phone:__________________________ Employer Name:______________________________

Insurance Information

Do you have dental insurance? Yes/No Do you have secondary dental insurance? Yes/No

Primary Dental Insurance		**Secondary Insurance**	
Subscriber Name		Subscriber Name	
Subscriber ID#		Subscriber ID#	
Subscriber SSN		Subscriber SSN	
Date of Birth		Date of Birth	
Relationship to Subscriber		Relationship to Subscriber	
Employer Name		Employer Name	
Employer Phone		Employer Phone	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Insurance Phone #		Insurance Phone #	
Please Present Insurance Card to Receptionist			

Is there anyone that you would allow Bradley W White DDS to discuss your treatment, appointments, or your financial obligations with ? Yes/No If yes, please request a HIPAA form from the front desk personnel. You must complete this form before we can discuss your care with anyone.

Referred by:____

Health Information – Confidential

Date of Last Dental Visit: ___________________________ Date of Last X-Ray:_______________________

Reason for Today's Visit: ____

Name of Physician: _________________ Office Phone Number: __________ Date of Last Physical: ________

Do you take blood thinners such as Aspirin, Coumadin, Plavix, etc.? Yes/No

Are you or have you ever taken any bisphosphonates such as Fosamax, Actenol, Boniva, etc.?_________________

List any medications you are taking including non-prescription drugs: _____________________________________

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Do you have a history of:	Y	N		Y	N		Y	N
Rheumatic Fever			Arthritis			Unhealed injuries or inflamed areas in or around your mouth		
Stroke			Kidney Disease			Bleeding gums		
Heart Murmur			H.I.V. Positive			Bad taste or odor in your mouth		
Heart Trouble			Excessive Bleeding			Pain in our jaw or near your ears		
Anemia			Any artificial joint replacement			Popping or clicking in jaws or TMJ		
High Blood Pressure			Epilepsy			Treated/diagnosed with TMJ disorder		
Heart abnormalities since birth			Ulcers or stomach problems			Sinus problems		
Pace Maker/Open Heart Surgery			Hepatitis			Any difficult tooth extractions in the past		
Diabetes			Lung disease			Trouble from previous dental care		
Liver Disease			Asthma			Growth or sore spots in mouth		
Fainting/Dizziness			Tuberculosis			Allergic reactions to anesthetics		
Venereal Disease			Any surgery or radiation treatment			Any part of mouth sensitive to pressure or irritants (hot, cold)		
Other Illnesses:								

WOMEN	Y	N		Y	N
Is there a possibility of pregnancy?			Are you nursing?		
Estimated due date			Are you taking birth control?		

Have you ever had any adverse/allergic reactions to any medications? Yes/No
If so please list medications:____

Have you ever had any adverse/allergic reaction to latex? Yes/No

I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any member of his staff responsible for any errors that I have made in the completion of this form.

Patient/ Guardian Signature:____Date____________________