★GET ACQUAINTED QUESTIONNAIRE★

★★Payment Is Expected When Services Are Rendered★★

All X-Rays remain the property of this office; duplicates are available upon request for a fee with 24 hr. notice.

Today's Date:_______________ **Years Since Last Dental Visit:**__________________

Patient's Name:________________________________ **Date of Birth:**____________________

Last First MI

(If patient is under 18, parent or guardian's name:_________________________) **Male** or **Female** (circle one)

Home Address: ______________________________________ **City**________________________

State_________________ **Zip** _______________ **Home Phone:** (______)__________________

Cell Phone: (______)_________________________ **Work Phone:** (______)__________________

Employed By: _____________________________ **Position:** __________________________

Email: ___________________________________ **Spouse's Name:** ______________________

Spouse's Employer: ________________________ **Spouse's Phone:** (______)________________

Do You Have Insurance That May Cover Any Part of Our Professional Services? Yes ☐ No ☐

Name of Insurance Company: ______________________ **Insured's Soc. Sec. #:** _____-______-________

Name of Insured (Employee): ______________________ **Insured's Date of Birth:** _________________

Insurance Company Phone: (______)_________________ **Group #:** ___________________________

☆☆☆

Who May We Thank For Referring You Here? _______________________________________

CONFIDENTIAL MEDICAL HISTORY- **PLEASE READ CAREFULLY And Mark Yes or No**

Do You Currently Have or Ever Have Any of the Following (If there are 2 choices, please circle the appropriate one)?

High Blood Pressure / Stroke	No☐	Yes☐	Circulatory Problems	No☐	Yes☐	
Heart Murmur / Prolapsed Valve	No☐	Yes☐	Artificial Joints	No☐	Yes☐	Year:
Heart Problems / Stents / Pacemakers	No☐	Yes☐	Radiation Treatment	No☐	Yes☐	Year:
Rheumatic Fever / Scarlet Fever	No☐	Yes☐	Previous History of Bleeding / Anemia	No☐	Yes☐	
Epilepsy / Nervous Problems	No☐	Yes☐	Diabetes	No☐	Yes☐	Type I or II
Tuberculosis	No☐	Yes☐	HIV / AIDS	No☐	Yes☐	
Liver / Kidney Problems	No☐	Yes☐	Hepatitis / Yellow Jaundice	No☐	Yes☐	Type A B C
Asthma / Lung Diseases	No☐	Yes☐	Currently Pregnant (Women Only)	No☐	Yes☐	
Reaction to Anesthetic	No☐	Yes☐				

List ALL Medications You Are ALLERGIC To: ____

List ALL Medications You Are TAKING: ____

-Please sign both if applicable-

-I hereby understand that I am responsible for all costs of Dental treatment at the time services are rendered.

-I hereby authorize payment of group insurance benefits directly to Five Star Dental that are otherwise payable to me.

-I hereby authorize release of any information relating to this claim.

______________________________ ___________

Signed Patient (or parent if minor) DATE

__________________________ _________

Signed- Insured Person DATE