Acquaintance Form & Health History

Patient Name _____ DOB _____ SS # _____ Single ____ Married ____

Spouse/Parents name(s) _____ DOB _____ SS # _____

Address _____ City_____ State_____ Zip _____

Home # _____ Cell #_____ Work # _____ Spouse/Parent's # _____

E-mail Address _____ Authorize confirmation texts and/or emails? Yes_____No_____

Employed by _____ Whom may we thank for this referral? _____

Emergency contact _____ Relationship _____ Phone # _____

Dental Insurance Information

Primary

Insured Name_____DOB _____

Insurance Company _____

Address_____

Group #_____ ID # _____

Phone #_____

Secondary

Insured Name_____ DOB _____

Insurance Company _____

Address _____

Group #_____ ID # _____

Phone # _____

What prompted you to seek dental care at this time?_____

How long since your last dental examination? _____ Cleaning? _____ X-rays? _____

At your last dental visit, what treatment was provided? _____

Name of previous Dentist _____ Phone # _____

May we request dental x-rays/records? Yes _____ No _____

Have you been treated by a dental specialist? If yes, name _____ Phone # _____

How often do you have your teeth examined? _____

Has the fear of discomfort kept you from regular dental visits? _____

Would you prefer a local anesthetic for most dental treatment? _____

Are you satisfied with your past dentistry? _____

How often do you brush your teeth? _____

Are you troubled with bad breath?_____ Dry Mouth?_____

Do your gums bleed easily, feel tender or irritated? _____

Are your teeth sensitive to hot, cold or sweets? _____

Do you frequently snack between meals on sweets, or starches, or chew gum? _____

Are you self-conscious about the appearance of your teeth? _____

Would you like to retain your healthy natural teeth as long as possible? _____

Do your jaws feel tired? _____

Do you have pain in the head, neck, shoulders, or back? _____

Do you have clicking or popping noises when opening or closing your mouth? _____

Are you aware of grinding or clenching of your teeth? _____

I grant authority to Dr. Jeff Baggett & Dr. Grady Lembke to perform dental and surgical procedures and treatments, including the administration of medicines and local anesthetics, that are deemed necessary and advisable. I also authorize Dr. Jeff Baggett and Dr. Grady Lembke's offices to release any information necessary to expedite insurance claims. I understand that I am ultimately responsible for ANY and ALL charges regardless of insurance coverage.

Authorized signature: _____ Date: _____

HEALTH HISTORY

Physician's Name _____ Physician's Phone Number_____ Last Visit_____

When was your last thorough medical examination?_____

Are you being treated by a physician now? Yes _____ No _____

Do you exercise regularly? _____ What form of exercise do you do?_____

Taking any medications? Yes_____ No_____ Identify _____

_____

_____

Identify any vitamins or nutritional supplements you take _____

Allergic to medications? Yes_____ No_____ Identify_____

Allergic to **latex**? Yes____ No____ Allergic to metals? Yes_____ No _____ Identify_____

Any serious illness or surgeries? Yes____ No____ Identify _____

_____

_____

Has it been recommended that you **premedicate** with antibiotics prior to dental treatment? Yes_____ No_____

Reason_____ Medication_____ Dr. _____ Phone # _____

ANY HISTORY OF

AIDS or HIV Positive	Yes ____ No ____	Hepatitis	Yes ____ No ____
Allergic to Anesthetic	Yes ____ No ____	High Blood Pressure	Yes ____ No ____
Alzheimer's Disease	Yes ____ No ____	Joint Replacement	Yes ____ No ____
Anemia or Blood Disorders	Yes ____ No ____	Kidney, Liver Disorder Or Jaundice	Yes ____ No ____
Arthritis	Yes ____ No ____	Lung Disease	Yes ____ No ____
Artificial Heart Valve	Yes ____ No ____	Malignancies, Tumors Or Cancer	Yes ____ No ____
Asthma	Yes ____ No ____	Currently Pregnant	Yes ____ No ____
Autoimmune Disorder	Yes ____ No ____	Prolonged Bleeding	Yes ____ No ____
Cold Sore/Fever Blisters	Yes ____ No ____	Radiation Treatments	Yes ____ No ____
Diabetes	Yes ____ No ____	Rheumatic Fever	Yes ____ No ____
Emotional Stress	Yes ____ No ____	Smoking/Smokeless Tobacco	Yes ____ No ____
Epilepsy	Yes ____ No ____	Stroke	Yes ____ No ____
Eye Disorders	Yes ____ No ____	Taking Fluoride Supplement	Yes ____ No ____
Heart Trouble, Murmur	Yes ____ No ____	Venereal Disease or Herpes	Yes ____ No ____

_____ _____

Patient or Parent Signature Date