CHRISTINE BLOSS, D.D.S., P.C.

ACQUAINTANCE FORM

Today's Date_____

NAME LAST	FIRST	MIDDLE Initial	NICKNAME	SEX	BIRTH DATE	AGE

ADDRESS: Street City State Zip How long at current address:

Home Phone Work Phone Cell / Pager E-Mail

Employer Present Position Social Security No.

Spouse or Significant Other Employer Social Security No.

MEDICAL HISTORY

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING SUBSTANCES?

Acetaminophen
Aspirin
Codeine
Ibuprofen
Keflex
Penicillin
Iodine
Local Anesthetic
Latex
Metal
Nitrous Oxide

Are you aware of being allergic to any other medications or substances?_____

_____

_____

HAVE YOU EVER HAD THE FOLLOWING:

1. Head or neck injuries	YES	NO	5. Emotional problems	YES	NO
2. Prolonged bleeding due to a slight cut	YES	NO	6. Psychiatric treatment	YES	NO
3. Radiation therapy	YES	NO	7. Antidepressant medication	YES	NO
4. Chemotherapy	YES	NO	8. Subject to frequent headaches	YES	NO

PHYSICIAN(S):

BLOOD PRESSURE:

Do you have any condition that may possibly affect dental treatment? YES NO If so, reason:

Are you currently under medical treatment? YES NO If so, what:

For women: Are you pregnant? YES NO Taking Birth Control pills? YES NO

List any medications, supplements, or vitamins you presently take:

Have you had any serious illness or surgery in the past 5 years? YES NO If so , explain:

Have you ever taken any of the group of drugs referred to as "Fen-Phen" or Redux: YES NO
Have you had any heart damage or pulmonary complications?

Have you taken or are you currently taking any medications for bone mineral density or osteoporosis, in the class called Bisphosphonates (brand names include Fosamax, Actonel, Aredia, or Zometa)? YES NO
If so, which medication, for how long, and for what condition?

Have you ever had an orthopedic total joint replacement? Hip Knee Shoulder Elbow Finger

Date_____ If yes, have you had any complication?_____

What Is Your Estimate Of Your General Health?
Poor_____Fair_____Good_____

Do you use tobacco? YES NO
If yes, would you be interested in quitting?

DENTAL HISTORY

Who may we thank for referring you to our office?_____

Previous dentist_____ How long_____

Most recent dental exam_____ Most recent dental x-rays_____

Most recent dental treatment_____

How often do you have your teeth cleaned? 3 mo._____ 4 mo._____ 6 mo._____ 1 year or longer_____

WHAT ARE YOUR IMMEDIATE DENTAL CONCERNS?_____

_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

1. Unhappy with the appearance of your teeth	YES	NO
2. Unfavorable dental experiences	YES	NO
3. Dental fears	YES	NO
4. Problems with dental anesthetic or hard to numb	YES	NO
5. Orthodontic treatment (braces)/When	YES	NO
6. Are you concerned about bad breath	YES	NO
7. Periodontal (gum) treatment/When	YES	NO
8. Bleeding, Swollen, or Tender Gums	YES	NO
9. Avoid brushing any part of your mouth	YES	NO
10. Part of your mouth is sensitive to temperature	YES	NO
11. Sore teeth	YES	NO
12. A burning sensation in your mouth	YES	NO
13. Difficulty swallowing	YES	NO
14. An unpleasant taste or odor in your mouth	YES	NO
15. Dry mouth	YES	NO
16. Jaw Joint problems, temporomadibular joint, or TMJ pain	YES	NO
17. Difficulty opening your mouth widely	YES	NO
18. Jaw clicking or popping	YES	NO
19. Have you ever worn a Nightguard?	YES	NO
20. Stiff neck muscles	YES	NO
21. Awaken with an awareness of your teeth, jaws, or muscles	YES	NO
22. Tension headaches	YES	NO
23. Clench or grind your teeth	YES	NO
24. Herpesvirus "Cold Sores"	YES	NO
25. Canker Sores (aphthous ulcers)	YES	NO
26. Do you chew on one side of your mouth	YES	NO
27. Does your bite fit together evenly	YES	NO
28. Lost any teeth	YES	NO
29. Do you sweat or tremble a lot during examination	YES	NO
30. Do strange people or places make you afraid	YES	NO

COMMENTS

DO YOU WEAR DENTURES OR PARTIAL DENTURES? If so, please complete the following:

UPPER: Full Denture / Partial Denture since _____

LOWER: Full Denture / Partial Denture since _____

If you are wearing a Partial or Complete Denture, Please complete the following:

YES NO Is your present denture a problem? Describe_____

YES NO Satisfied with the appearance?_____

YES NO Satisfied with the chewing ability?_____

YES NO When did you receive your first partial or complete denture?_____

YES NO Has your present denture been relined? When_____

NOTES_____

_____

_____

_____Doctor's Signature_____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Problems	Anemia or Blood Problems	Allergies or Hives	Hepatitis	Hiatal Hernia
Angina Pectoris	Hemophilia Bleeding Problems	Sinus Trouble	Thyroid Disease	Cancer or Tumors
High Blood Pressure	A.I.D.S./A.R.C./HIV Pos	Drug or Alcohol Dependency	Diabetes	Cortisone Medicine
Heart Murmur	Emphysema	Sexually Transmitted Disease	Seizures	Arthritis
Rheumatic Fever	Tuberculosis (TB)	Kidney Trouble	Ulcers	None
Stroke	Asthma	Liver Disease/Jaundice	Digestive Disorder	

EMERGENCY CONTACT INFORMATION (Relative not living with you)

Name:	Relationship:
Address, City, State, Zip	Phone

ACKNOWLEDGMENT & RELEASE

I hereby authorize my insurance benefits where applicable to be paid directly to the dentist.
I am financially responsible for any balance due and authorize the dentist to release any information for this claim.
I authorize that the records can be used by the doctor as he so determines.
In consideration of the services rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy.
I consent to the making of photographs, x-ray films, and videotapes before, during and after treatment, and to the use of same by the doctor in scientific papers, demonstrations or lectures, or marketing.
I certify that I have read or had it read to me the contents of this form and do realize the risks and limitations involved.

PATIENT'S SIGNATURE_____ **DATE**_____

MEDICAL CONDITIONS & MEDICATIONS UPDATES

For staff use only

Date	Changes		Patient's Initials	BP	Reviewed By
		None			
		None			
		None			
		None			
		None			
		None			