

Get Acquainted Questionnaire

| Full Name: | Date of Birth: | v/mm/dd |
|--|--|-------------------------------|
| | | <i>y</i> , |
| Home Address: | Telephone: () | |
| Postal Code: | renephones | |
| Email Address: | ` | |
| Whom may we thank for referring you to our off | ter | |
| Medical History If you | ere unsure of any of the following question. | s, please ask for assistance. |
| Name of physician: | () | |
| Are you under the care of a specialist? Yes | No | |
| Name of specialist: | Telephone: () | |
| | | Yes No |
| Have you had a medical examination in the last y | ar? | |
| Have you had a serious illness? | | 0 0 |
| Is your doctor treating you now? | | 0 0 |
| Have you been warned not to take certain medic | tions or food? | 0 0 |
| Do you have any allergies? | | 0 0 |
| Do you have any allergies? Have you had an unusual reaction to any medica | on or injection? | |
| Do you have Diabetes? | | |
| Do you have high blood pressure? | | |
| Have you ever had Rheumatic Fever or Scarlet F | ver? | |
| Do you have abnormal bleeding? | | 0 0 |
| Have you had any previous surgery? | | 0 0 |
| Are you taking any prescription or non-prescript | on medicines regularly? | |
| Please list, indicating purpose and frequency of u | e: | |
| | | |
| | | |
| | الماست منسلا | |
| Have you had any ill effects from any of the follo | ving? (please circle) deine Advil Barbituates | Latex |
| Penicillin 292 Aspirin Co | | Latex |
| Others: | | |
| Is your eyesight: Good Adequate Po | or (please circle) | |
| Do you wear corrective lenses? | | |
| Do you have hearing difficulties? | | |
| Have you had any organ transplants, pacemaker | r medical artificial implants? | |
| Do you have any condition that could affect you | immune system (eg. AIDS liver disease | |
| HIV positive, Splenectomy, Leukemia, etc.)? | | |
| Do you bruise or clot slowly? | | |
| Do you smoke or chew tobacco? | | |
| Frequency? | | |
| For women only: | | |
| Are you pregnant | | |
| If so, what month | are you in? | |
| Do you take birth | control pills? | |
| | | 300 300 |



Get Acquainted Questionnaire - contid

| | of the follow | ing | | | |
|---|--|--|--|--|---|
| Chest Pains | | Arthritis | 0 | Heart Murmur | |
| Stroke | 0 | Blood Disorders | | Heart Disease | 0 |
| Bronchitis | | Dizziness | 0 | Diabetes | |
| Asthma | | Cancer | 0 | Liver Disease | |
| Tuberculosis | _ | Stomach Ulcers | 0 | Hepatitis | |
| Drug/Alcohol Addiction | | Sinusitis | | Local page System Company | |
| Joint Replacement | 0 | Ulcers | | Epilepsy | |
| HIV | | A THE THE PARTY OF | | Herpes Venereal Disease | |
| Kidney Disease | 0 | Thyroid Disease Emphysema | | venereal Disease | |
| Is there any other medical Please identify: | condition/pro | blem the doctor sho | ould be aware of | Yes □ No | 00 |
| Personal Data: | | | | | |
| Employed by: | | Occu | pation: | - 62 | |
| Business Phone: | | Marit | | 52 | |
| Spouses Name: | | Empl | loyed by: | | |
| Person responsible for this | account: | | 52 57% | | |
| Address if different from a | bove: | | | | |
| In case of emergency pleas | e call: | 2000 Marie 2000 000 | — Telephone | :() | |
| Do you have dental incura | nce? Yest | NI - I | | | |
| 20 Jou mare demai misura | nee. resu | Nou Insurance (| Company Name | : | |
| Policy/Group Number: | | Certific | Company Name ate/ID Number | | |
| Policy/Group Number: Do you have secondary ins | surance throug | h your spouse? Yes D | Company Name ate/ID Number 1 Non Spouse | : : 's date of birth: | -//44 |
| Policy/Group Number: Do you have secondary ins | surance throug | h your spouse? Yes C | ate/ID Number No Spouse | : 's date of birth: y | y/mm/dd |
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Date:____

Get Acquainted Questionnaire - cont'd

| When was your last dental examination? When was your last full mouth series of x-rays of jaws and teeth? Who was your last dentist? Why did you change dentists? How often do you brush your teeth? What other dental aids do you frequently use? Do any medical problems impede your cleaning abilities? Do your gums bleed with flossing? Do you presently have any pain in chewing? Do you have any missing teeth? Do you notice any clicking or cracking of the jaws in opening? Do you notice any clicking or cracking of the jaws in opening? Have you ever had a tooth extracted? If yes, were there any complications? Are you aware of bad breath or tastes in your mouth? Has any of your previous dental work been done with a local anaesthetic? Do you bite your cheeks or lips frequently? Do you bite your cheeks or lips frequently? Are you tense during dental visits? Fear Deain Embarrassment Other Derivative in sports? Do you wear recommended mouth guard protectors? | Full Name: | Date of Birth: | /mm/dd | |
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| Are you tense during dental visits? Are there emotional concerns regarding your dental visit? Fear Pain Embarrassment Other Are you active in sports? Do you wear recommended mouth guard protectors? Check any of the following that you are interested in: Orthodontics (Braces) Bonding (Esthetic Straightening) Replacing missing teeth Whitening teeth Sports Mouth Guard | Do you bite your cheeks or lips frequently? | | | |
| Are you tense during dental visits? Are there emotional concerns regarding your dental visit? Fear Pain Embarrassment Other Are you active in sports? Do you wear recommended mouth guard protectors? Check any of the following that you are interested in: Orthodontics (Braces) Bonding (Esthetic Straightening) Replacing missing teeth Whitening teeth Crowns (Caps) Sports Mouth Guard | Do you smoke? Cigarettes | Pipe Cigars Number per day: . | | |
| Fear Pain Embarrassment Other D Are you active in sports? Do you wear recommended mouth guard protectors? Check any of the following that you are interested in: Orthodontics (Braces) Bonding (Esthetic Straightening) Replacing missing teeth Whitening teeth Other D Improving Improving gum health Improving breath Crowns (Caps) Sports Mouth Guard | Are you tense during dental visits? | - | | |
| Are you active in sports? Do you wear recommended mouth guard protectors? Check any of the following that you are interested in: Orthodontics (Braces) Bonding (Esthetic Straightening) Replacing missing teeth Whitening teeth Sports Mouth Guard | Are there emotional concerns regarding yo | ur dental visit? | | |
| Check any of the following that you are interested in: Orthodontics (Braces) Bonding (Esthetic Straightening) Replacing missing teeth Whitening teeth Sports Mouth Guard | Fear D Pain D Embarrass | ment Other | | |
| Check any of the following that you are interested in: Orthodontics (Braces) Bonding (Esthetic Straightening) Replacing missing teeth Whitening teeth Sports Mouth Guard | Are you active in sports? | | | |
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| Orthodontics (Braces) Bonding (Esthetic Straightening) Replacing missing teeth Whitening teeth Improving gum health Improving breath Crowns (Caps) Sports Mouth Guard | | | | |
| Orthodontics (Braces) Bonding (Esthetic Straightening) Replacing missing teeth Whitening teeth Improving gum health Improving breath Crowns (Caps) Sports Mouth Guard | Check any of the following that you are in | terested in: | | |
| Bonding (Esthetic Straightening) Replacing missing teeth Whitening teeth U Sports Mouth Guard | | | lth 🗖 | |
| Replacing missing teeth | | | | |
| Whitening teeth | | Crowns (Cane) | _ | |
| Improving bite and smile | • | Sports Mouth Guar | d n | |
| Improving the and sinie | • | Implants | | |
| | improving bite and smile | Limpiants | ш | |
| If you could change the appearance of your teeth in any way, what would you change? | _ | □ Implants | | |
| | | | | |
| | | | | |
| | Thank You! | | | |

Signature: _

| Scanned | with | CamScanner |
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