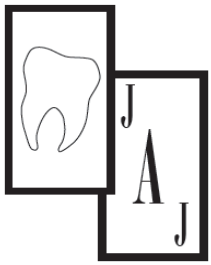

Jamie J. Alexander, D.D.S., PA
Cosmetic, Implant and General Dentistry

Acquaintance Form

Date: _____

First Name: _____MI:_____ Last Name: _____

Address: _____

City: _____State: _____Zip Code: _____

Home Phone # _____Cell # _____ Work #_____

E-mail Address_____

What are the most convenient method(s) to confirm your dental appointments?

□ Home Phone □ Cellular Phone □ Office Phone □ E-mail □ Text Message

Date of Birth: _____ Social Security #: _____

Employer: _____Occupation: _____

Business Address: _____

Person Responsible for My Account: _____

Whom May We Thank For This Referral: _____

Married:_____ Single:_____ Widowed:_____ Divorced:_____ Committed Relationship:_____

Dental Insurance Information:

Do you have Dental Insurance Benefits: Yes:_____ No:_____ If Yes, Please Complete Below:

Dental Insurance Company: _____

Mailing Address: _____

_____

City/State/Zip: _____

Telephone: _____

Policy Number: _____

Group Number: _____

Policy Holder: _____

Policy Holder Birth Date: _____

Policy Holder Social Security Number: _____

Relationship to Patient: _____

Policy Holder Employer: _____

Signature:_____ Date: _____

Jamie J. Alexander, D.D.S., PA
Cosmetic, Implant and General Dentistry

Health History Form

Your (Previous) Dentist's Name:_____ Last Visit Date:_____

Telephone # _____ Address: _____

Do you recall your last dental cleaning visit? Yes:_____ No:_____ If Yes, Please indicate date? _____

Do you have current radiographs (x-rays) Yes:_____ No:_____ If Yes, Please indicate date taken? _____

Are you currently having any urgent dental needs (pain, discomfort , area of mouth, how long, etc.)

If Yes, Please explain: _____

_____

_____

Your Physician's Name:_____Telephone # _____ Last Visit Date:_____

Are you currently being treated by a physician? Yes:_____ No:_____

Are you allergic to any medications? Yes:_____ No:_____

If Yes, What? _____

Any recent illness or changes in your health? Yes:_____ No:_____

If Yes, What? _____

Are You Regularly Pre-Medicated with Antibiotics for a Dental Visit? Yes:_____ No:_____ If Yes, What? _____

Are You Currently Taking Any Blood Thinning Medications? Yes: _____ No: _____ If Yes, What? _____

Are you currently or have you previously taken oral bisphosphonates (ex. Fosamax)

Yes: _____ No: _____If Yes, for how long? _____

Have you noticed any unexplained weight loss or weight gain? Yes:_____ No:_____

Do you experience unrestful sleep, or awake in the morning overly tired? Yes:_____ No:_____

Do you experiences headaches Yes: _____ No: _____ If Yes, how often? _____

Do you use tobacco? Yes: _____ No: _____ If Yes, for how long? _____

Notes: _____

_____

_____

_____

Jamie J. Alexander, D.D.S., PA
Cosmetic, Implant and General Dentistry

Health History Form

Any History Of:

Medications:

Allergy Or Adverse Reaction To Dental Anesthetic	Yes: _____ No: _____	_____
Arthritis	Yes: _____ No: _____	_____
Artificial Joints	Yes: _____ No: _____	_____
Asthma	Yes: _____ No: _____	_____
Cancer	Yes: _____ No: _____	_____
Chemical Dependence (Alcohol/ Drug)	Yes: _____ No: _____	_____
Diabetes	Yes: _____ No: _____	_____
Emotional Stress	Yes: _____ No: _____	_____
Epilepsy	Yes: _____ No: _____	_____
Glaucoma	Yes: _____ No: _____	_____
Headaches	Yes: _____ No: _____	_____
Heart or Valve Problems	Yes: _____ No: _____	_____
Heart Murmur	Yes: _____ No: _____	_____
Hepatitis	Yes: _____ No: _____	_____
High Blood Pressure	Yes: _____ No: _____	_____
HIV + or AIDS	Yes: _____ No: _____	_____
Kidney, Liver or Bladder Disease	Yes: _____ No: _____	_____
Pregnant Currently	Yes: _____ No: _____	_____
Prolonged Bleeding	Yes: _____ No: _____	_____
Rheumatic Fever	Yes: _____ No: _____	_____
Sinus Trouble/Hay Fever	Yes: _____ No: _____	_____
Sleep Apnea (Chronic unrestful sleep)	Yes: _____ No: _____	_____
Smoking/Tobacco Use	Yes: _____ No: _____	_____
Stroke	Yes: _____ No: _____	_____
Thyroid Disease	Yes: _____ No: _____	_____
Tuberculosis	Yes: _____ No: _____	_____

Notes _____

_____

Jamie J. Alexander, D.D.S., PA
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**Our office is dedicated to the concept that all people should have the right to retain their natural teeth for a lifetime. Preventative measures, high quality care, and good cooperation combined with timely treatment make it possible for most people to retain their natural teeth with optimum comfort, function, and appearance. My staff and I are dedicated to this concept and with your cooperation we will do everything we can to help you reach your goals for dental health.*

Circle One:

1. My…
   A) mouth is very comfortable.
   B) mouth is moderately comfortable.
   C) mouth is uncomfortable.

2. I…
   A) think the appearance of my mouth is excellent.
   B) am satisfied with the appearance of my mouth.
   C) am dissatisfied with the appearance of my mouth.

3. I…
   A) will do anything to keep my natural teeth.
   B) want to keep my teeth, but have a certain budget of time and money that I am willing to spend on them.
   C) don't care whether I keep them or not.

4. I…
   A) have set goals for my oral health with a previous dentist.
   B) want to set goals concerning my oral health.
   C) have never set goals for my oral health.

5. I…
   A) have always done the best that was recommended for my dental health.
   B) have not done what dentists recommended for my mouth.
   C) rarely go, and don't care much about having any dental work completed.

6. I have…
   A) put dentistry for myself and my family high on my priority list.
   B) put dentistry for myself and my family low on my priority list.
   C) dentistry on my list but is hard to find.

7. I think my present state of dental health is:
   A) Excellent
   B) Good
   C) Poor

8. I aspire to a mouth with:
   A) Excellent Health
   B) Good Health
   C) Poor Health

9. What are some questions about dentistry and oral health that you have never had adequately answered?

   _____

   _____

10.	Are your teeth as white and bright as you would like them to be?	YES	NO
11.	When you look at your teeth, do you see too much gray or black in the back of your mouth?	YES	NO
12.	Are your teeth as straight as you would like them to be?	YES	NO
13.	Do you like the way your teeth are shaped?	YES	NO
14.	Do you like the way your gums look?	YES	NO
15.	Lightening, brightening, straightening, and re-contouring are easy procedures. Are you interested in knowing about them?	YES	NO