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 #_____

Date of Birth: _____ Social Security #: _____

Person Responsible for My Account: _____

Whom May We Thank For This Referral: _____

Dental Insurance Information:

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: _____

*** Insurance is not a form of payment in our office. Fees are due at the time services are rendered. We will be happy to file your claim form for you. We cannot render service on the assumption that the charge will be paid by your insurance company.

Patient Lives with…. Mother and Father Mother Father Other _____

Parent or Guardian Signature: _____ Relationship to Patient: _____

Parent of Guardian Print Your Name: _____ Date: _____

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HEALTH HISTORY

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

Are You Currently Being Treated By a Physician? Yes:_____ No:_____

Are You Taking Any Medications (This Includes All Over-The-Counter Drugs as well as Prescribed Drugs) Yes:_____ No: _____

If Yes, What?_____

Are You Allergic to Any Medications? Yes:_____ No:_____

If Yes, What? _____

Any Recent Serious Illness?_____

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

Any History Of:		**Medications:**
Allergy Or Adverse Reaction To Dental Anesthetic	Yes: _____ No: _____	_____
Artificial Joints	Yes: _____ No: _____	_____
Asthma	Yes: _____ No: _____	_____
Cancer	Yes: _____ No: _____	_____
Childhood Diseases (mumps, measles)	Yes: _____ No: _____	_____
Diabetes	Yes: _____ No: _____	_____
Emotional Stress	Yes: _____ No: _____	_____
Epilepsy/Seizure Disorder	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: _____	_____
Learning Disability	Yes: _____ No: _____	_____
Pregnant Currently	Yes: _____ No: _____	_____
Prolonged Bleeding	Yes: _____ No: _____	_____
Rheumatic Fever	Yes: _____ No: _____	_____
Sinus Trouble/Hay Fever	Yes: _____ No: _____	_____
Stroke	Yes: _____ No: _____	_____
Thyroid Disease	Yes: _____ No: _____	_____
Tuberculosis	Yes: _____ No: _____	_____

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DENTAL HISTORY

Dental Experiences:

Is this the first dental visit for this patient? Yes: _____ No: _____

Previous significant trauma to face or jaws? Yes: _____ No: _____ Explain:_____

Do you anticipate patient having difficulty accepting dental treatment?

Yes: _____ No: _____ Explain:_____

Has this patient ever been seen or treated for orthodontics (braces)?

Yes: _____ No: _____ Explain:_____

Are your child's teeth as straight as you would like them to be?

Yes: _____ No: _____ Explain:_____

Eating Habits:

Bottle given between meals Yes: _____ No: _____ Content:_____

Bottle given at bedtime Yes: _____ No: _____ Content:_____

Sippy cup given between meals Yes: _____ No: _____ Content:_____

Juices/Soda Pop given between meals Yes: _____ No: _____ How Often:_____

Snack given between meals Yes: _____ No: _____ What:_____

Oral Habits:

Has the patient ever had any history of the following oral habits?

Pacifier Yes: _____ No: _____

Thumb/Finger Sucking Yes: _____ No: _____

Mouth Breating Yes: _____ No: _____

Nail Biting Yes: _____ No: _____

Grinds Teeth Yes: _____ No: _____

Other Yes: _____ No: _____ Explain:_____

Flouride History:

Fluoride toothpaste used Yes: _____ No: _____ Brand:_____

Fluoride mouth rise used Yes: _____ No: _____ Brand:_____

Fluoride supplements used Yes: _____ No: _____ How long:_____

My water at home is…

A) City water.
B) Private well.
C) Bottled water.

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Oral Hygiene:

1.My child…

A) brushes their teeth rarely.
B brushes their teeth once a day.
C) brushes their teeth two times a day.
D) brushes their teeth after each meal and before bed.

2.My child…

A) flosses their teeth rarely.
B) flosses their teeth once a month.
C) flosses their teeth once a week.
D) flosses their teeth daily.