Get Acquainted Questionnaire

Welcome to our office!

We feel you will be pleased with the care you will be receiving. In order to begin treatment, the following information is necessary. Please complete fully and PRINT legibly. All information will be held in strict confidence. Thank you for joining our family of patients.

----------CONFIDENTIAL PATIENT INFORMATION----------

PATIENT INFORMATION

Patient's Name_____ DOB_____ Age _____ Sex _____

Home Phone _____ Cell Phone _____ E-mail _____

Preferred method of contact (Check all that apply) : □ Cell Phone □ Home Phone □ Work Phone □ Text □ E-mail

Address_____Apt #_____ SS# _____

City _____ State _____ Zip _____ Who does patient reside with? _____

Emergency Contact Name _____ Relation to patient _____

Emergency Contact Phone number _____

Why are you here today? ☐ Routine Check-up ☐ Toothache ☐ Braces ☐ Improve Smile ☐ Other_____

I give Dino Kids' Dental permission to contact me with announcements, surveys and other messages. Y / N (*You may opt out of these communications at any time. Please notify our front desk*.)

We use this information to provide you with excellent treatment. We may disclose Patient Health Information (PHI) to third parties that perform services for Dino Kids' Dental in the administration of your benefits in accordance with HIPPA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. PHI may be disclosed to an affiliate that performs services for Dino Kids' Dental in the administration of your benefits. Our affiliates do not sell, share or rent our patients personal identifiable information unless it is required by law, do not send any e-mail or other communication without the patients permission.

RESPONSIBLE PARTY'S INFORMATION

Please note only the parent/legal guardian can sign and consent for dental treatment for a minor patient. A form of identification, and if needed, legal documentation must be submitted prior to any dental treatment being performed on the patient.

Parent/Guardian Name _____ DOB _____ SSN # _____

Relationship to Patient: □ Parent □ Step parent □ Guardian □ Other _____

Guardian Marital Status: □ Single □ Married □ Divorced □ Widowed □ Significant Other

If divorced/separated, who is the custodial parent? (*please provide legal documentation*)

Home Phone _____ Cell Phone _____ E-mail _____

Mailing Address _____Apt #_____

City _____ State _____ Zip _____

Occupation _____ Work Phone _____

Does anyone other than a biological parent have legal custody? ☐ Yes ☐ No

If yes, who? (*please provide legal documentation*)

Guardian Name _____ Phone Number _____

Dental Insurance _____ |Secondary Dental Insurance ☐ Yes ☐ No

Name of Subscriber _____ |Name of Subscriber _____

CONSENT TO FINANCIAL RESPONSIBILITY

This is the certify that I, the undersigned, consent to the performing of whatever dental services and/or surgical procedures may be decided upon to be necessary or advisable, and to the use of local or general anesthetic as may be deemed advisable by the dentist. I have also been explained the consequences of partial and/or no treatment. I hereby authorize my dentist to release any and all medical information (including dental information) to the above-named insurance carrier for purposes of claims administration, evaluation, utilization, review, and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing.

I hereby authorize my insurance carrier to pay directly to the within named dentist(s) the dental benefits otherwise payable to me. I understand if my insurance company does not pay in full, I am responsible for the remaining balance. I understand some dental services I receive may require a co-payment from me. The amount of the co-payment will vary according to the insurance/dental plan I have and the procedure that is performed. If my insurance/dental plan has a yearly deductible, I understand it must be satisfied before treatment begins. I also understand co-payments must be paid in full at the time of treatment. A finance charge of 1.5% per month (18% annual) will be charged on the unpaid principal balance on all accounts not paid within 30 days of the date of service.

I further understand dental services not covered by my insurance/dental plan may be prescribed in certain cases by the attending dentist. Usual, customary, and reasonable fees will be charged for such services.
I also understand there will be a charge for any missed appointment which is not canceled within 24 hours in advance.

Patient/Guardian Signature _____ **Date** _____

Patient's Name	Date of Birth

These questions are for your benefit and assure that treatment will take into consideration the patient's past and present health status. Some questions may seem unrelated to your dental concern, but they are all associated with proper oral health care. Please answer each question and mark YES or NO as appropriate.

Medical History (If patient is a minor, parent/guardian must answer the following questions pertaining to the patient's health)

		YES	NO
1.	Are you in good health?	☐	☐
2.	Are you now under the care of a physician? If so, what is the condition being treated? _____ Physician name/phone #/address _____	☐	☐
3.	Have you ever had any serious illness or operation? If so, what illness or operation? _____	☐	☐
4.	Have you ever been hospitalized? If so, what was the problem? _____	☐	☐
5.	Are you taking medications? Or any recreational drugs? If so, what? _____ What dosage? _____ If so, what? _____ What dosage? _____ If so, what? _____ What dosage? _____	☐	☐

6. Are you sensitive or allergic to any drugs or material(s)? ☐ Penicillin ☐ Tetracycline ☐ Sulfa Drugs ☐ Aspirin ☐ Codeine ☐ Other: If other, what drug(s) or material(s)? _____
7. Do you have, or have had any of the following:

YES	NO		YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Heart Murmur	☐	☐	Joint Replacement	☐	☐	Epilepsy or Seizures	☐	☐	Anemia	☐	☐	Liver Disease
☐	☐	High Blood Pressure	☐	☐	Allergies or Hives	☐	☐	Heart Ailments or Attach	☐	☐	Ulcers	☐	☐	Sinus Trouble
☐	☐	Radiation Therapy	☐	☐	Cortisone Medicine	☐	☐	Hepatitis	☐	☐	Glaucoma	☐	☐	Blood Disease
☐	☐	Rheumatic Fever	☐	☐	Excessive Bleeding	☐	☐	Fainting Spells or Seizures	☐	☐	Arthritis	☐	☐	Drug Addiction
☐	☐	Tuberculosis	☐	☐	Latex Allergy	☐	☐	Chemotherapy	☐	☐	Emphysema	☐	☐	Kidney Disease
☐	☐	Cardiac Pacemaker	☐	☐	Pain in Jaw Joints	☐	☐	Venereal Disease (Syphilis, Gonorrhea)	☐	☐	Cold Sores	☐	☐	HIV/AIDS
☐	☐	Nervous Disorders	☐	☐	Respiratory Disease	☐	☐	Artificial Prosthesis	☐	☐	Bruise Easily	☐	☐	Asthma
☐	☐	Thyroid Disease	☐	☐	Mental Disorder	☐	☐	Angina Pectoris	☐	☐	Head Injuries	☐	☐	Hemophilia
☐	☐	Tumors or Growths	☐	☐	Psychiatric Treatment	☐	☐	Congenital Heart Lesions	☐	☐	Diabetes	☐	☐	Stroke
☐	☐	Blood Transfusions	☐	☐	Cerebral Palsy	☐	☐	Heart Surgery (Valve replacement)	☐	☐	Prosthetic Joints	☐	☐	Jaundice

		YES	NO
8.	Do you have any disease, condition or problem not listed that you think we should know? If so, what? _____	☐	☐
9.	Do you smoke? If yes, how much per day? _____	☐	☐
10.	Are you currently taking, or have taken the drug Phen-Phen?	☐	☐
11.	(Female) Is there a possibility you may be pregnant?	☐	☐
12.	(Female) Do you have any problems associated with your menstrual period?	☐	☐
13.	(Female) Do you take birth control pills?	☐	☐

Dental History

1.	Have you ever had a local anesthetic (Novocaine, etc)?	☐	☐
2.	Have you ever had an unfavorable reaction from a local anesthetic?	☐	☐
3.	Have you had any serious trouble associated with any previous dental treatment? If so, please explain: _____	☐	☐

4. How long since your last full mouth x-rays? _____
5. How long since your last dental treatment? _____
6. If any current dental problem the result of an accident? ☐ Yes ☐ No When _____
7. Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will without fail, inform the doctor at my next appointment.

Patient/Guardian Signature _____ **Date** _____

Doctor's Signature _____ **Date** _____

DDS NOTES