DICKERSON FAMILY DENTAL

REIN M. DICKERSON DDS PLLC

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Welcome to our office. We will do our best to make your appointment as convenient and pleasant as possible. If at any time you have questions regarding your treatment, your appointments or fees, please feel free to ask. This acquaintance form will help us to serve you better.

Date ____________________

Patient Name ____
LAST FIRST MIDDLE

Street ______________________________ Apt. # ______________

City ______________________________ State __________ Zip Code __________

Home Ph. __________ Cell __________ Work __________ E Mail __________

Date of Birth ____/____/____ Sex: Male ______ Female ______ Marital Status: __________

Drivers License # ____________________ Social Security # ____________________

Employer Information

Employed by ______________________________ Since ____________________

Street ____________________ City ____________________ State ______ Zip Code __________

Business Phone ____________________ Extension # ______________

Nearest friend or relative we may notify *in case of emergency* ____________________ *Ph. #* ____________

Whom may we thank for referring you? ______________________________

Name of your physician (family doctor) ______________________________ Ph. # ____________

Pharmacy Name ______________________________ Ph. # ____________

Spouse Information / Person Financially Responsible / Insurance Policy Holder

Name ____
LAST FIRST MIDDLE

Street ____________________ City ____________________ State __________ Zip Code __________

Home Phone ____________________ Cell Phone # ____________________

Date of Birth ____________ Sex: Male ______ Female ______ Social Security # ____________________

Employed by ______________________________ Phone ____________________

Street ____________________ City ____________________ State __________ Zip Code __________

Insurance Information

Patients dental insurance carriers name ____

Street ____________________ City ____________________ State __________ Zip Code __________

Group number ______________________________ Policy number ____________________

Please Fill In Back Side

MEDICAL HISTORY

CIRCLE

1. Are you having pain or discomfort at this time? .... Yes .... No
2. Do you feel very nervous about having dental treatment? .... Yes .... No
3. Have you ever had a bad experience in the dental office? .... Yes .... No
4. Have you been a patient in the hospital during the past two years? .... Yes .... No
5. Have you been under the care of a medical doctor during the past two years? .... Yes .... No
6. Have you taken any medicine or drugs during the past two years? .... Yes .... No
7. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes or made sick by penicillin, aspirin, codeine, or any drugs or medications, local anesthetic, latex?) .... Yes .... No
8. Have you ever had any excessive bleeding requiring special treatment? .... Yes .... No
9. Circle any of the following which you have had or have at present:

Heart Failure	Stroke	X-Ray or Cobalt Treatment	Blood Transfusion
Heart Disease or Attack	Kidney Trouble	Chemotherapy (Cancer, Leukemia)	Chemical Dependency
Angina Pectoris	Ulcers	Arthritis	Hemophilia
High Blood Pressure	Emphysema	Rheumatism	Venereal Disease
Heart Murmur	Cough	Cortisone Medicine	(Syphilis, Gonorrhea)
Rheumatic Fever	Tuberculosis (TB)	Glaucoma	Cold Sores
Congenital Heart Lesions	Asthma Inhaler	Pain in Jaw Joints	Genital Herpes
Mitral Valve Prolapse	Hay Fever	AIDS (HIV) Positive	Epilepsy or Seizures
Artificial Heart Valve	Sinus Trouble	Hepatitis A (infectious)	Fainting or Dizzy Spells
Heart Pacemaker	Allergies or Hives	Hepatitis B (serum)	Nervousness
Heart Surgery	Diabetes	Liver Disease	Psychiatric Treatment
Artificial Joint	Thyroid Disease	Yellow jaundice	Sickle Cell Disease
Anemia			Bruise Easily

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath or because you are very tired? .... Yes .... No
11. Have you lost or gained more than 10 pounds in the past year? .... Yes .... No
12. Are you on a special diet? .... Yes .... No
13. Has your medical doctor ever said you have a cancer or tumor? .... Yes .... No
14. Do you have any disease, condition, or problem not listed? .... Yes .... No
15. WOMEN: Are you pregnant now? .... Yes .... No
    Are you practicing birth control? .... Yes .... No
    Do you anticipate becoming pregnant? .... Yes .... No
16. Have you ever taken Fenphen or Redux? .... Yes .... No
17. Do you use any tobacco product? Smoking, Chewing, Dipping .... Yes .... No
    If yes, how much? ____________________

DENTAL HISTORY

YES ___NO ___ DO YOU WANT TO KEEP YOUR NATURAL TEETH?
YES ___NO ___ HAVE YOU VISITED A DENTIST IN THE LAST YEAR
YES ___NO ___ DO YOU HAVE PROBLEMS CHEWING YOUR FOOD?
YES ___NO ___ ARE ANY OF YOUR TEETH SENSITIVE TO COLD, SWEETS, HOT, PRESSURE?
YES ___NO ___ DO YOUR GUMS BLEED?
YES ___NO ___ GUMS SWOLLEN OR TENDER?
YES ___NO ___ SORES OR GROWTHS IN THE MOUTH?
YES ___NO ___ BAD BREATH?
YES ___NO ___ HAVE YOU LOST ANY TEETH (BRACES, ACCIDENT, DECAY)?
YES ___NO ___ DO YOU GRIND YOUR TEETH?
YES ___NO ___ DO YOU HAVE PAIN OR CLICKING IN YOUR JAW JOINT?
YES ___NO ___ HAVE YOUR WISDOM TEETH BEEN REMOVED?
YES ___NO ___ DO YOU SNORE?
YES ___NO ___ TROUBLE BREATHING THROUGH NOSE?
YES ___NO ___ DO YOU FLOSS YOUR TEETH DAILY?
YES ___NO ___ HAVE YOU EVER WORN BRACES?

What is the main concern about your teeth? ____________________

Please list any prescription or over the counter medications, vitamins or herbs taken routinely. ____________________

____

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

___/___/___ Date

____________________ Signature of Parent, Patient, or Guardian

____________________ Doctor's Signature