 Patient:_____

Current Physician_____ Last Visit_____

Are you being treated by a physician now? YES NO

Are you taking any medications? YES NO Identify_____

Allergies to medications, metals or latex? YES NO Identify_____

Any recent illness or surgeries? YES NO Identify_____

Personal Health History:

It is very important for us to know any health history that you may have so that we can treat you accordingly. All information is confidential.

Please place an X beside all that apply:

Anemia	____	Liver Disease	____
ADHD/ADD	____	Lupus	____
Autism/Aspersers	____	Mental Disorders	____
Arthritis	____	Nervous Disorders	____
Artificial Joints	____	Pacemaker	____
Asthma/Lung Disorder	____	Osteoporosis	____
Auto Immune Disorder	____	Radiation TX	____
Behavior Disorder	____	Respiratory Problems	____
Blood Disease	____	Rheumatic Fever	____
Cancer	____	Rheumatism	____
Diabetes	____	Sinus Problems	____
Dizziness	____	Stomach Problems	____
Epilepsy	____	Stroke	____
Excessive Bleeding	____	Thyroid	____
Fainting	____	Tuberculosis	____
Glaucoma	____	Tumors	____
Head Injuries	____	Venereal/Herpes	____
Heart Attack/Disease	____	Tobacco	____
Heart Murmur	____	Alcohol	____
Hepatitis	____	Pregnancy	____
High Blood Pressure	____	Nursing	____
HIV/AIDS	____	Periodontal Disease	____
Kidney Disease	____	Taking fluoride supplements	____

Non of the above apply to me _____

_____ _____

Patient or Guardian Signature Today's Date

_____

Brian Chastain, D.D.S.

ACQUAINTANCE FORM & HEALTH HISTORY

Patient's Name _____ SS # _____ Today's Date _____

Patient's Date of Birth _____ Age _____ Single Married M F

Address _____ City _____ Zip _____

Email Address _____ Home Phone _____ Cell Phone _____

Your Employer _____ BusinessPhone_____
Bussiness Address _____

Spouse's Name _____ Date of Birth _____ Age _____

Spouse's Employer _____ Spouse's Cell Phone _____

Business Address _____ Spouse's SS # _____

Whom may we thank for this referral? _____

Emergency Contact Name _____ Phone _____

Dental Insurance? YES NO

Dental Insurance Company _____ID# or SS#_____

Employee _____DOB_____Group# _____

What prompted you to seek dental care at this time? _____

How long since your last thorough dental examination? _____ Cleaned? _____ X-Rayed? _____

Has fear of the dentist kept you from regular dental visits? YES NO

Are you satisfied with your past dentist? YES NO

How often do you brush your teeth? _____ How often do you floss? _____

Are you troubled with bad breath?	YES NO
Do you frequently snack between meals on sweets, starches or gum?	YES NO
Are your teeth sensitive to hot, cold or sweets?	YES NO
Do your gums bleed easily, feel tender or irritated?	YES NO
Are you self-conscious about the appearance of your teeth?	YES NO
Do your jaws ever feel tired?	YES NO AM PM
Do you have pain in the head, neck, shoulders or back?	YES NO
Do you have clicking or popping noises when opening your mouth?	YES NO
Are you aware of grinding or clenching your teeth?	YES NO
Do you want to change anything about your smile?	YES NO

Name of your previous dentist _____

May we request your previous dental records to facilitate proper treatment in our office? _____

I understand that I am responsible for payment when services are rendered unless other arrangements have been made. If insured, I understand that I am responsible for payment of my co-insurance the day of treatment and that I will be billed for any balance that my insurance does not pay. I hereby authorize my group insurance benefits payable to Dr. Brian Chastain, D.D.S., otherwise payable to me.
*** *In order to assure quality care at reasonable fees, we must assess $25 to anyone missing or canceling an appointment with less than a 48-hour notice* ***

_____ _____

Patient or Guardian Signature Today's Date