ACQUAINTANCE FORM & HEALTH HISTORY

Today's Date _____

Child's Name _____ M or F Date of Birth _____ Age _____

Father's Name _____ Mother's Name _____

Address _____ City _____ Zip _____

Email Address _____ Home Phone _____ School Attending _____

Father's Employer _____ D.O.B _____ Cell Phone _____

Mother's Employer _____ D.O.B _____ Cell Phone _____

Emergency Name _____ Home Phone _____ Cell Phone _____

Person Responsible for Account _____

Whom may we thank for this referral? _____

Dental Insurance? YES NO Employee Name _____ SS #_____

Insurance ID # _____ Group # _____

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

How long has it been since your child's last thorough dental examination? _____ Cleaned? _____ X-Rayed? _____

Has your child had a bad experience at the dentist? _____

How often does your child brush his/her teeth? _____

Does your child frequently snack between meals on sweets, starches or gum? YES NO

Does your child clench or grind his/her teeth? YES NO

Name of 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**

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/Aspergers	____	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.