Patient Information

Date_____

Patient's_____
Last First Middle

Address_____
Street City State Zip

Home Phone_____ Birthdate_____ Social Security #_____

If patient is a minor, give parent's or guardian's name_____

Whom may we thank for referring you to our office?_____

Responsible Party Information

Name _____ _____
Last First Middle Marital Status

Residence_____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address?_____Home #_____ Work #_____

Previous address (If less than 3 years)_____
Street City State Zip

Cell Phone # _____ Email Address _____

Social Security #_____ Birthdate_____ Relationship to patient_____

Employer_____Occupation_____ # of Years Employed_____

Spouse's Name_____ Relationship to Patient_____
Last First Middle

Employer_____Occupation_____ # of Years Employed_____

Social Security # _____ Birthdate_____Work #_____

Insurance Information

Insured's Name _____ Insured's SS #_____

Insurance Company_____Group #_____Ins Co. Phone # _____

Insurance Co.address_____

Do you have dual coverage? ____Yes _____No If yes:

Insured's Name_____ Insured's SS #_____

Insurance Company _____ Group #_____ Ins Co. Phone #_____

Insured's Employer_____

Emergency Contact Information (other than responsible parties)

Name _____Relation_____

Complete Address _____

Phone #_____

I understand by signing below I am authorizing a credit file to be processed by Experian.

Signature (Parent's signature if minor)_____

CHRIS CRUZ, D.D.S.

ADULT GET AQUAINTED QUESTIONNAIRE

Sex:_____ Age:_____ Birthdate:____-____-_____Height: _____ Weight: _____

Ethnicity : Anglo American____African American____American Indian_____
Asian_____ Chinese____ Japanese_____ Korean____ Pacific Islander____ Latin____
We need ethnicity information for diagnosis purposes only.

Have you had unfavorable reaction to dental care?_____

Reason for consultation? _____

Do you desire orthodontic treatment? _____

GENERAL HEALTH
Any history of (circle the condition): Heart trouble, heart murmur, rheumatic fever, allergies, hepatitis, positive HIV, diabetes, asthma, kidney or liver involvement, epilepsy, bleeding disorders, mental disorders, etc.?_____
_____
Have you had any operations?_____
Are you presently taking any medications? (RX, over the counter or herbal including osteoporosis medications ie: Fosamax) _____
_____
Have you ever had an allergic reaction to any medications?_____
If so, what medication?_____

Are you sensitive to latex? _____

Has it ever been recommended that you take antibiotics prior to dental procedures? ____
_____

Do you use tobacco products? _____
Any previous orthodontic treatment?_____
Accidents/Trauma to mouth or teeth?_____

ORAL HABITS: Thumb sucking, etc? _____ Nail biting?_____
Mouth breathing? _____ Lip or tongue biting? _____

VOICE: Speech: _____ Stammer: _____ Lisp: _____

PRESENT HEALTH: Excellent:_____ Good:_____ Fair:_____Poor:_____
Your dentist: _____ Your physician: _____

Your E-Mail Address _____

Health History Update:

Date:_____	Date:_____	Date: _____
Initials: _____	Initials: _____	Initials: _____
Changes: _____	Changes: _____	Changes: _____