PREMIER FAMILY DENTAL

24307 Southland Drive
Hayward, CA 94545

ACQUAINTANCE FORM

PATIENT INFORMATION – PLEASE PRINT CLEARLY

Mr. ☐ Mrs.☐
Miss☐ Ms. ☐_____ Date of Birth_____

Address_____ Apt.#_____ City _____ State____ Zip_____

Home Phone ( ) _____Work Phone ( )_____

Cell Phone ( )_____ e-mail _____

Social Security Number_____ Age _____ Driver's License Number _____

Name of Physician _____ Physician's Phone ( ) _____

Referred by_____ Occupation _____

Emergency Contact Name_____ Phone ( )_____

RESPONSIBLE PARTY INFORMATION IF PATIENT IS A MINOR

Name _____ Relationship_____

Address_____ Apt.#_____ City _____State ____Zip_____

Home Phone ( ) _____ Work Phone ( )_____

Cell Phone ( )_____e-mail _____

Social Security Number_____ Date of Birth _____ Driver's License Number _____

EMPLOYER/INSURANCE INFORMATION

Employer _____ Employer phone ( )_____

Employer Address _____ City_____ State____ Zip_____

Do you have Dental Insurance? Yes ☐ No ☐ Name of Insurance_____

Insurance Address_____ City _____State ____Zip_____

Insurance Phone ( ) _____ Policy Number_____Group/Local Number_____

Name of Insured Person First_____ Middle_____ Last_____

Social Security Number_____ Date of Birth _____

ARE YOU COVERED UNDER ANOTHER INSURANCE? Yes☐ No☐

Name of Insurance_____ Policy Number_____ Insurance Phone ( )_____

Insurance Address _____ City _____State ____Zip_____

Name of Insured Person First_____ Middle_____ Last_____

Social Security Number _____ Date of Birth _____

Employer _____ Employer phone ( )_____

Employer Address _____ City_____ State_____ Zip_____

ACKNOWLEDGEMENT AND AUTHORITY

This is my consent for the dentistry indicated on the examination chart. I also agree to the use of a local anesthetic and pre-medication or sedation depending upon the judgement of the dentists involved in my case. I have been informed of all probable complications of the dentistry, anesthesia, premedication, sedation and other drugs. I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, AT THE TIME OF SERVICE, unless other arrangements are made with the office representative. We reserve the right to charge for appointments cancelled or broken without 24 hours advance notice.

Signed: _____ Date: _____

PREMIER FAMILY DENTAL
Family Dentistry & Orthodontics

MEDICAL HISTORY UPDATE (v.2)

Name: _____ **Date:** _____

Phone: _____ **Address:** _____

DOB: _____ **E-mail:** _____

Have you ever had any of the following diseases or medical problems? (circle all that apply)

Abnormal Bleeding	**Epilepsy**	**Liver Disease**	**HIV+**	**TB**
Diabetes	**Seizures**	**Hepatitis**	**AIDS**	**Heart Attack/Stroke**

Please list any conditions not listed: _____

Does your physician recommend antibiotics prior to dental cleanings or treatment? **YES** **NO**

If YES, please give us a copy of your prescription for our records.

Have you taken or are currently taking Bisphosphonates (i.e. Fosamax, Boniva)? **YES** **NO**

Are you currently taking any blood thinner medications (i.e. Coumadin, Heparin, Warfarin)? **YES** **NO**

Are you currently taking prescription pain medication? **YES** **NO**

If YES, please give us a copy of your prescription for our records.

Please list any other medications you are taking (prescription and over-the-counter):

Are you allergic to any of the following? (circle all that apply):

Penicillin **Latex** **Hydrocodone** **Codeine** **Clindamycin** **Erythromycin**

Please list any medications you cannot take:

Do you have a persistent cough? **YES** **NO**

Have you traveled outside the US in the last 6 months? **YES** **NO**

Women:

Are you taking birth control pills? (Antibiotics can render birth control pills ineffective) **YES** **NO**

Are you pregnant? **YES** **NO**

If YES, list months or weeks:

PATIENT/PARENT/GUARDIAN SIGNATURE: _____

DOCTOR SIGNATURE: _____