STERLING POINTE DENTAL PRACTICE
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GET ACQUAINTED QUESTIONNAIRE

IN ORDER FOR US TO BETTER SERVE YOU, PLEASE FILL IN THE FOLLOWING INFORMATION *COMPLETELY*: (COMPLETE BOTH SIDES)

Patient's Name:_____ Age:_____ Date of Birth:_____ M F

Phone#_____ Cell#_____ Social Security#_____ Driver's License#_____

Address:_____ City_____ State_____ E-mail (optional):_____

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

If patient is a full-time college student, fill in school name, City/State_____

Emergency Contact:_____ Ph#( )_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE/OR HOW DID YOU HEAR ABOUT OUR PRACTICE?_____

RESPONSIBLE PARTY INFORMATION

Name:_____ Martial Status:_____

Soc. Sec#_____ Date of Birth:_____ Relationship to patient_____

Residence:_____

Mailing Address If Different from Residence:_____

Employer_____ Occupation_____

Employer Address_____

Spouse's Name_____ Date of Birth_____ Soc. Sec#_____

Employer_____ Occupation_____

Employer Address_____

INSURANCE INFORMATION

Insured's Name_____ Insured's Soc. Sec.#_____

Insured's Date of Birth_____ Insurance Co._____ Group#_____

Authorized to Assign Benefits. Insured Signature_____

Is patient covered by another Insurance Plan? Yes ____ No ____

If yes: Name of person carrying Insurance:_____ Date of Birth_____

Soc Sec#_____ Name of Ins. Co._____ Group#_____

Authorized to Assign Benefits. Insured Signature_____

DENTAL INFORMATION

Do your gums bleed when you brush?	Yes	No	Do you wear a nightguard?	Yes	No
Are your teeth sensitive to heat or cold?	Yes	No	Do you wear a Partial or Full Denture?	Yes	No
Do you grind or clench your teeth?	Yes	No	Do you smoke or chew tobacco?	Yes	No
Do you have any fear of dental work?	Yes	No	Are you having pain or discomfort at this time?	Yes	No

Date of last dental visit_____ What was done at the time?_____

Date of last dental cleaning_____ Have you ever been told that you have gum disease or had gum surgery?_____

Former Dentist Name_____ City_____

How would you describe your current dental problem?_____

How do you feel about the appearance of your teeth?_____

I acknowledge that I have received the Dental Materials Fact Sheet.

Patient's Signature_____ Date_____

MEDICAL INFORMATION

1. Have you been a patient in the hospital during the last two years? YES NO
2. Are you now taking any medication or drugs? YES NO

   If yes, please list ALL:_____

3. A. Have you taken any medication or drugs during the last two years? YES NO

   B. Have you ever taken appetite suppressants – fen-phen (fenfluramine & phentermine) or dexfenfluramine or fenfluramine? YES NO
4. Have you been under the care of a medical doctor during the last two years? YES NO

   Physician's Name_____Ph#_____

   Address_____
5. Are you sensitive or allergic to any medication or anesthetics? YES NO

   If yes, please list:_____
6. Indicate which of the following you have had or have at the present. Circle "yes or no" to each item.

Heart Failure	Yes No	Artificial Joints (Hip, Knee, etc.)	Yes No	Hepatitis	Yes No
Heart Disease or Attack	Yes No	Kidney Disease	Yes No	If yes, which strain?	A B C
Angina Pectoris	Yes No	Ulcers	Yes No	Venereal Disease	Yes No
Congenital Heart Disease	Yes No	Diabetes	Yes No	A.I.D.'s	Yes No
Heart Murmur	Yes No	Thyroid Problems	Yes No	H.I.V. Positive	Yes No
High Blood Pressure	Yes No	Glaucoma	Yes No	Cold Sores/Fever Blisters	Yes No
Arteriosclerosis	Yes No	Osteoporosis	Yes No	Blood Transfusion	Yes No
Mitral Valve Prolapse	Yes No	Emphysema	Yes No	Hemophilia	Yes No
Artificial Heart Valve	Yes No	Chronic Cough	Yes No	Anemia	Yes No
Heart Pacemaker	Yes No	Tuberculosis	Yes No	Sickle Cell Disease	Yes No
Heart Surgery	Yes No	Asthma	Yes No	Bruise Easily	Yes No
Rheumatic Fever	Yes No	Hay Fever	Yes No	Liver Disease	Yes No
Arthritis	Yes No	Allergies or Hives	Yes No	Yellow Jaundice	Yes No
Rheumatism	Yes No	Sinus Trouble	Yes No	Epilepsy or Seizures	Yes No
Cortisone Medicine	Yes No	Radiation Therapy	Yes No	Fainting or Dizzy Spells	Yes No
Drug Addiction	Yes No	Chemotherapy	Yes No	Neurological Disorder	Yes No
Stroke	Yes No	Developmentally Disabled	Yes No	Tumors	Yes No
Allergy to Latex	Yes No	Allergy to Metal	Yes No	Cancer	Yes No
Taking Blood Thinner	Yes No			If yes, location?_____	

7. When you walk up stairs, do you ever have to stop due to pain in your chest, shortness of breath, or because you are very tired? YES NO
8. Do your ankles swell during the day? YES NO
9. Have you lost or gained more than ten pounds in the past year? YES NO
10. Do you have or have you had any disease, condition, or problem not listed? YES NO

    If yes, please list:_____

FOR WOMEN ONLY:

Are you Pregnant? YES_____What Month?_____NO_____Are you nursing: YES____NO___Are you taking birth control pills? YES___NO___

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature_____Date_____

CONSENT:

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient)_____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 ½% finance charge (18% APR) may be added to my account, in addition to any collection fee charged.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any change in the information obtained on this form.
6. I authorize the use of my social security number to file my dental claim.

Patient Signature_____Date_____

If Patient is a Child, Signature of Parent or Responsible Party_____Relationship to Patient_____

FOR OFFICE USE: Reviewed By Dr._____Date:_____

Meds Review:_____

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