ROSSVILLE
FAMILY DENTAL

This Acquaintance Form will help us to serve you better. We will do our best to make your appointments as convenient and pleasant as possible. Please feel free to ask our staff if you have questions regarding your treatment, your appointments, or fees. We are glad you are here!

PLEASE PRINT. FOR CHILDREN, 17 OR YOUNGER ONLY

Patient's Name_____ Birthdate_____ Age_____ Sex_____
First Name Middle Initial Last Name Month Day Year

Soc.Sec.No._____ Home Phone No._____

Home Address_____ City_____ Zip_____

Father's Name_____ Soc.Sec.No._____

Birthdate_____ Home Phone # _____

E-mail Address_____ Cell # _____

Home Address_____ City_____ Zip_____

Employer_____ Business Phone No._____

Mother's Name_____ Soc.Sec.No._____

Birthdate_____ Home Phone # _____

E-mail Address_____ Cell # _____

Home Address_____ City_____ Zip_____

Employer_____ Business Phone No._____

Subscriber's Name: _____ **Subsriber's Birthdate:**_____

Dental Insurance_____ Dental Ins. Phone_____

Group # or Plan #_____ Subscriber ID#_____

Person Responsible for Bill_____ Birthdate_____

Relationship to you_____ Soc.Sec.No._____

Billing Address_____ Phone No._____

Dental Insurance_____ Group No. or Plan No._____

Whom may we thank for referring you to us?_____

APPOINTMENTS: We work by appointment only so your wait will be minimal and your treatment done efficiently. To help us serve you better we ask for 2 business days notice for changes in your appointment.

INSURANCE: To avoid misunderstanding regarding dental insurance, we want our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

SIGNATURE_____ **DATE**_____
(Parent or Guardian's signature)

Patient's Name_____ **Date of Birth**_____
First Name Middle Initial Last Name Month Day Year

DENTAL HISTORY

Please check any of the following your child ever had:

- ☐ Teeth sensitive to cold, heat, sweets, etc.
- ☐ Bleeding gums, How Long?_____
- ☐ Food impaction
- ☐ Clenching or grinding
- ☐ Burning of tongue
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain around ears
- ☐ Clicking or popping in ear while eating
- ☐ Bad Breath
- ☐ Unpleasant taste
- ☐ Complications from extractions
- ☐ Periodontal treatment
- ☐ Orthodontic treatment (braces)
- ☐ Mouth breathing
- ☐ Tongue thurst
- ☐ Oral habits, i.e. finger nail biting, cheek biting, ect.
- ☐ Thumb sucking

Please check any of the following your child uses:

- ☐ Dental floss
- ☐ Inter dental stimulators
- ☐ Water jet device
- ☐ Disclosing tablets or solutions
- ☐ Fluoride supplements
- ☐ Tooth brush, frequency of brushing? _____

MEDICAL HISTORY

Has your child had any of the following?

- ☐ Allergies to drugs WHICH?_____
- ☐ Allergies to anesthetics WHICH?_____
- ☐ Any heart ailments
- ☐ High blood pressure
- ☐ Neurological problems
- ☐ Radiation treatments
- ☐ Excessive bleeding from cut or extraction
- ☐ Anemia or blood problems
- ☐ Arthritis
- ☐ Asthma
- ☐ Hay fever or other allergies
- ☐ Diabetes
- ☐ Veneral disease
- ☐ Acquired Immune Defiency Syndrome
- ☐ Liver problems or hepatitis
- ☐ Malinancies (cancer)
- ☐ Psychiatric care/emotional problems
- ☐ Rheumatic fever
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Eye disorders
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcer of colitis
- ☐ Kidney problems
- ☐ Drug or Alcohol dependency
- ☐ Epilepsy

Physician's Name_____ Date of last physical exam_____

Pharmacy of Choice: _____ Phone # _____

Is your child presently under a physician's care? _____ If so, why? _____

Is your child presently taking any medications? _____ If so, why? _____

SIGNATURE_____

(Parent of Guardian's Signature)