



THOMAS V. WHINERY D.D.S.

RESTORATIVE DENTISTRY

ACQUAINTANCE FORM

Our office is dedicated to the concept that all people should have the right to retain their natural teeth for a lifetime. Preventative measures, high quality care and good cooperation (combined with timely treatment) make it possible for most people to retain their natural teeth with optimum comfort, function and appearance. Our staff is dedicated to this concept and with your cooperation we will do everything possible to help you reach your goals for dental health.

Name _____ Today's Date _____ Marital Status S M D W

Home Address _____ City _____ Zip _____

Birth Date _____ Res Tel (____) _____ Bus Tel (____) _____ Cell (____) _____

Email _____ How did you choose our office? _____

HAVE YOU EVER HAD: Please circle

- | | |
|------------------------------------|-------------------------|
| Heart Disease or Heart Attack | AIDS |
| Heart Murmur | HIV Positive |
| Rheumatic Fever | Cancer |
| Mitral Valve Prolapse | Chemotherapy |
| Artificial Heart Valve | Radiation Therapy |
| Abnormal Blood Pressure | Tuberculosis |
| Heart Pacemaker | Asthma |
| Artificial Joint (hip, knee, etc.) | Anemia |
| Hepatitis | Sinus Problems |
| Diabetes | Epilepsy or Seizures |
| Arthritis | Emotional Stress |
| Thyroid Problems | Osteoporosis/Osteopenia |

ARE YOU ALLERGIC TO

- | | |
|-------------------------------|---------|
| Antibiotics eg: Penicillin | |
| Codeine | Aspirin |
| Dental Anesthetic (Novocaine) | Latex |
| Other _____ | |

Do you use tobacco? _____

Do you snore? Yes No

Do you have sleep apnea? Yes No

Are you in Good Health Now? Yes No

FOR WOMEN ONLY:

Are you pregnant? Yes No

Do you take birth control pills? Yes No

Hormone replacement therapy? Yes No

LIST ANY DRUGS YOU ARE CURRENTLY TAKING AND FOR WHAT REASONS: _____

DATE OF LAST DENTAL VISIT: _____ WHAT WAS DONE? _____

PLEASE ADD ANYTHING YOU FEEL IS IMPORTANT: _____

Physician _____ Telephone _____ Date of last complete physical _____

DENTAL HISTORY

Would you say your mouth is: comfortable uncomfortable?

At your visit we will want to learn about any history of gum problems. Have you been treated for gum disease? Have your parents? Do your gums bleed on brushing or flossing?

Do you frequently have cold sores/fever blisters? Yes No

Do you have chronic bad breath/taste in your mouth? Yes No

Do you have tooth sensitivity to: Heat Cold Sweet Biting Pressure

At your visit we will need to investigate the mechanics of your jaw, joint, tooth and muscle system. Please write any thoughts you have about headaches, joint popping or gravelly sounds; avoidance of chewy foods; worn or chipped teeth, sensitive teeth.

Do you clench your teeth? Yes No

Have you worn braces? Yes No Have your teeth shifted? Yes No

Do you have any thoughts about the appearance of your smile? Tooth color? Alignment? Size or shape?

Would you rate your past dental experiences as: Excellent Good Poor

What are some questions about dentistry you have never had adequately answered?

Have you ever thought about what it would take to keep your teeth the rest of your life?

Yes No

RESPONSIBLE PARTY

Name _____ Birth Date _____

Address _____

Home Phone _____ Driver's License # _____ Sex M F

Work Phone _____ Responsible Party's Social Security # _____

Spouse's Name _____ Spouse's Employer _____ Spouse's Bus. Tel. _____

Insured name _____ Insured's Social Security # _____

Insurance Co. _____ Policy # _____ Group# _____

Preferred Method of Payment: CASH CHECK CREDIT CARD

CONSENT

You have my permission to ask the respective health care provider to release such information to you. I will notify the doctor or any change in my health or medication. I authorize the doctor or his staff to take any necessary x-ray, models, photos, and other diagnostic aids needed to make a thorough diagnosis of the patient's dental needs.

AGREEMENT TO PAY

Payment for dental services provided in this office for myself and my dependents are due and payable at the time services are rendered unless financial arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a billing acharge may be added to my account. I understand that I am ultimately responsible, regardless of insurance.

Signature _____ Date _____

(Patient, Parent, Guardian)