KOSTA J. ADAMS, DDS, MAGD, FICOI
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GENERAL IMPLANTOLOGY AND RESTORATIVE DENTISTRY
"Personalized Dental Care"

GET ACQUAINTED QUESTIONAIRE

Patient Name _____
Address _____
City _____ State _____ Zip _____
Home # _____ Cell # _____
Work # _____ Ext _____
E-mail Address _____

Date of Birth _____ Age _____
Social Security # _____
CDL # _____
Name of Spouse _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Occupation _____
Address _____

In case of emergency, who should be notified? _____ Phone # _____
Whom may we thank for referring you to our office? _____

INSURANCE #1 (PRIMARY)

Insured Person _____
Social Security # _____
Date of Birth _____ Group # _____
Insurance Company _____
Address _____
Phone #

INSURANCE #2 (SECONDARY)

Insured Person _____
Social Security # _____
Date of Birth _____ Group # _____
Insurance Company _____
Address _____
Phone #

YOUR DENTAL HISTORY

Former Dentist _____ Phone # _____ Date of Last Visit_____
How long since your last thorough examination with full mouth x-rays? _____
Why did you leave your last dentist? _____
What prompted you to seek dental care at this time? _____

DO YOU HAVE OR HAVE YOU EVER HAD… *Circle appropriate answer (Leave blank if you do not understand the question)*

YES	NO	Dental complaints/problem?	YES	NO	Growth or sore spots in your mouth?
YES	NO	Difficult extractions in the past?	YES	NO	Prolonged bleeding after extraction?
YES	NO	Wisdom teeth extracted?	YES	NO	Periodontal surgery?
YES	NO	Bleeding gums?	YES	NO	Are you in pain now?
YES	NO	Low back pain?	YES	NO	Pain in or near your ears/jaw?
YES	NO	Loose or sensitive teeth? Which side?	YES	NO	Chronic headaches, neck or shoulder pain?
YES	NO	A clicking jaw? *Sometimes* *Always*	YES	NO	Bleaching, either at home or by a dentist?
YES	NO	Unhealed injuries or inflammations in or around your mouth?			*Home* *Dentist*
			YES	NO	"Trench mouth" or other gum conditions?
YES	NO	Reaction to anesthetic (i.e. Novacaine)?	YES	NO	Mouth sensitivity to pressure or irritants (i.e.cold, sweets, etc.)?
YES	NO	Removable/fixed dentures or other appliances?			
YES	NO	Instruction on correct method of brushing your teeth?	YES	NO	Instruction on the care of your gums?

YES NO Do you chew on one side of your mouth? *Right* *Left*
YES NO Do you clench, grind or brux (gnash) your teeth?
YES NO Does any part of your mouth hurt when clenched?
YES NO Do your teeth and/or jaws ever feel "tired" when you wake up?
YES NO Do you have now, or have you ever had pain in your jaw or in the sides of your face about your ears?
YES NO Have you ever had partial or full-mouth orthodontic treatment?
YES NO Has antibiotic pre-medication prior to dental work ever been advised by your physician?
YES NO Have you ever had problems with prior dental treatment? *Explain* _____

DO YOU SNORE WHEN SLEEPING?
YES NO

YOUR MEDICAL HISTORY

Circle appropriate answer (Leave blank if you do not understand the question)

YES NO Is your general health good?
YES NO Has there been a change in your health within the last year?
YES NO Have you been hospitalized or had a serious illness in the last three years?
Why? _____
YES NO Are you being treated by a physician now? For what? _____
Physician _____ Address _____
Phone # _____ Date of last medical exam _____

HAVE YOU EXPERIENCED...

YES	NO	Chest pain (angina)?	YES	NO	Sinus problems?	YES	NO	Blurred vision?
YES	NO	Swollen ankles?	YES	NO	Difficulty swallowing?	YES	NO	Seizures?
YES	NO	Shortness of breath?	YES	NO	Frequent vomiting or nausea?	YES	NO	Jaundice?
YES	NO	Recent weight loss, fever or night sweats?	YES	NO	Dizziness?	YES	NO	Excessive thirst?
YES	NO	Persistent cough or coughing up blood?	YES	NO	Ringing in ears?	YES	NO	Dry mouth?
YES	NO	Bleeding problems or brusing easily?	YES	NO	Headaches?	YES	NO	Frequent urination?
YES	NO	Joint pain or stiffness?	YES	NO	Fainting spells?	YES	NO	Mood swings?

DO YOU HAVE OR HAVE YOU HAD…

YES	NO	Heart disease?	YES	NO	AIDS or ARC?	YES	NO	Prosthetic heart valve?
YES	NO	Heart attack or heart defects?	YES	NO	HIV positive?	YES	NO	Artificial joint?
YES	NO	Heart murmurs?	YES	NO	Tumor or cancer?	YES	NO	Blood transfusions?
YES	NO	Rheumatic fever?	YES	NO	Skin diseases?	YES	NO	Psychiatric care?
YES	NO	Pacemaker?	YES	NO	Anemia?	YES	NO	Emotional disorder?
YES	NO	Stroke or hardening of arteries?	YES	NO	Venereal disease?	YES	NO	Kidney/bladder disease?
YES	NO	High blood pressure?	YES	NO	Herpes?	YES	NO	Arthritis?
YES	NO	Chemotherapy and/or Radiation?	YES	NO	Contact lenses?	YES	NO	Family history of heart
YES	NO	TB, asthma, emphysema or lung disease?	YES	NO	Implants?			disease?
YES	NO	Stomach problems or ulcers?	YES	NO	Eye disease?	YES	NO	Family history of
YES	NO	Hospitalization?	YES	NO	Thyroid or adrenal disease?			diabetes or tumors?
YES	NO	Hepatitis or other liver diasease?	YES	NO	Surgeries?	YES	NO	Diabetes?

YES NO Treatment for osteoporosis? *Bisphosphonate drugs* (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®) *When?* _____

ARE YOU TAKING OR HAVE YOU TAKEN…

YES	NO	Recreational drugs?	YES	NO	Tobacco (in any form)?	YES	NO	Alcohol?
YES	NO	Drugs such as fen-phen for weight loss?	YES	NO	Bisphosphonates (IV, etc.)?	YES	NO	Drug dependent?
YES	NO	Drugs. Medicines (incl. aspirin)?	YES	NO	Dietary/Herbal supplements?	YES	NO	Abused drugs?
Please List: _____						YES	NO	Latex allergies?
If ALLERGIC to any medication, please list here: _____						YES	NO	Metal allergies?

WOMEN ONLY:

YES NO Are you or could you be pregnant? How many weeks? _____ Obstetrician Name _____
YES NO Are you taking any oral contraceptives or other hormonal therapy? YES NO Are you nursing?

ALL PATIENTS:

Do you have or have you had any other diseases or medical problems not listed on this form?
If so, please explain: _____

RESPONSIBILITY AND CONSENT STATEMENT To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. The undersigned hereby authorizes Doctor to initiate a collection of records for my comprehensive exam, consisting of radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with the patient named on this form and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand the responsibility for payment for Dental Services provided in this office for myself or my dependent's is mine, due and payable at the time services are rendered regardless of insurance coverage. I agree that Doctor's office will assist me in submitting all insurance claims as a courtesy only and that one claim per patient per visit will be submitted to my insurance carrier at no cost. I further acknowledge that any insurance coverage that I may have is an agreement between my insurance company, myself and/or my employer. I understand that a service charge of 1% per month (12% APR) is incurred on any unpaid balance after 30 days from the date the service was provided. If my account is referred for collection, I will be responsible for any attorney's fees and court costs necessary to collect the unpaid balance.

X_____ _____

Patient Signature/Guardian Signature (if minor) *Date* *Witness Signature* *Date*