



## New Patient Acquaintance Form

Name ( First, Middle, Last)		Home Phone	Work/Cell
Address		City	State Zip
Occupation	Employer	Email Address	
Date of Birth	Sex	SSN	Emergency Contact Name - Phone
Spouse's Name		Spouse's phone number	
How did you hear about our office?			

Insurance Information		
Name of Insured: _____		Is insured a current patient? _____
SSN: _____	Date of Birth _____	
Insurance company	Phone number	Group Number

\_\_\_\_\_ **Initials**      **Cancellation Policy:** As a courtesy to other patients, all cancellations must be made 24 hours in advance of any scheduled appointments. If cancellations occur after this time, your account may be charged a cancellation fee. If you do not show for your scheduled appointment, your account may be charged a "no-show" fee.

## Medical Information

<p>Are you currently under the care of a physician?    Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>Physician name / number</p>	<p>Have you had a serious illness, operation or been hospitalized in the past 5 years?    Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>If yes, please explain:</p>
<p>Has there been any change in your health in the last year?    Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>If yes, what condition?</p>	<p>Have you ever had a reaction to latex? Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>Have you ever had a reaction to metal or jewelry? Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>Have you ever had a reaction to any medication? Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>If yes. Please explain:</p>
<p>Do you have any food allergies? Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>If yes, please list:</p>	<p>Are you previously or currently taking bone metabolism medications?    Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>If yes, please list:</p>
<p>Do you use controlled substances (Drugs)?</p> <p>Yes <input type="checkbox"/>    No <input type="checkbox"/></p>	<p>Have you had an orthopedic total joint replacement?</p> <p>Yes <input type="checkbox"/>    No <input type="checkbox"/></p>
<p>Do you use tobacco?    Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>If Yes, are you interesting in stopping? Yes <input type="checkbox"/>    No <input type="checkbox"/></p>	<p>Women Only:</p> <p>Are you Pregnant    Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>Number of weeks: _____</p> <p>Taking Birth control pills or hormone replacement?    Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>Nursing?    Yes <input type="checkbox"/>    No <input type="checkbox"/></p>
<p>Are you taking any prescription or over-the-counter medications?    Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>If yes, please list: _____</p> <p>_____</p> <p>_____</p>	

## Medical History

Please mark your response to indicate if you have any of the following diseases

	Yes	No		Yes	No
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valves	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>
Coronary artery disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart defects	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	GI disease	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux / heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent infection	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Persistent swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Systemic lupus	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>			

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment    Yes    
 No

Do you have any disease, condition, or problem not listed above that you think I should know about?

If yes please explain \_\_\_\_\_

I understand the need for these questions to be answered truthfully. To the best of my knowledge the answers I have given are accurate. I also understand it is very important to report any changes in my medical status to my treating doctor as soon as possible, and I agree to do so. I give permission to my treating doctor to obtain from my physician information regarding my medical history, if needed to provide me the best possible treatment. I hereby authorize Dr. Cozby and the appropriate staff members to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate for my dental needs.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Dental History

When was the last time you saw a dentist?	What was done at that time?
What is the reason for your visit today?	
Have you ever been treated for periodontal disease?	Yes      No
Have you had braces before?	<input type="checkbox"/> <input type="checkbox"/>
Does dental treatment make you nervous?	<input type="checkbox"/> <input type="checkbox"/>
Have you had an unpleasant dental experience?	<input type="checkbox"/> <input type="checkbox"/>
How often do you floss? _____	
What type of toothbrush do you use? (circle one) Soft    Medium    Hard    Electric	
What other cleaning aids, devices or rinses do you use? _____	
Do you experience any of the following?	
Bleeding or sore gums	Yes      No
Bad Breath/unpleasant taste	<input type="checkbox"/> <input type="checkbox"/>
Tingling or burning tongue or lips	<input type="checkbox"/> <input type="checkbox"/>
Swelling or lumps in mouth	<input type="checkbox"/> <input type="checkbox"/>
Sores in mouth	<input type="checkbox"/> <input type="checkbox"/>
Food trapping between teeth	<input type="checkbox"/> <input type="checkbox"/>
Trouble swallowing without water	<input type="checkbox"/> <input type="checkbox"/>
	Yes      No
Loose teeth	<input type="checkbox"/> <input type="checkbox"/>
Sensitive to hot	<input type="checkbox"/> <input type="checkbox"/>
Sensitive to cold	<input type="checkbox"/> <input type="checkbox"/>
Sensitive to sweets	<input type="checkbox"/> <input type="checkbox"/>
Clicking or popping jaw	<input type="checkbox"/> <input type="checkbox"/>
Frequent headaches	<input type="checkbox"/> <input type="checkbox"/>
Grinding or clenching	<input type="checkbox"/> <input type="checkbox"/>

## Smile Evaluation

	Yes	No
Are you self-conscious when you smile in front of other people or in pictures?	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever cover your smile with your hand?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have old fillings or dental work that you don't like looking at?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wish your teeth were whiter?	<input type="checkbox"/>	<input type="checkbox"/>
Do you dislike the shape of your teeth ?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have spaces between your teeth that you don't like?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wish your teeth were straighter?	<input type="checkbox"/>	<input type="checkbox"/>
Are you unhappy with crowded or crooked teeth?	<input type="checkbox"/>	<input type="checkbox"/>
If you could wave a "magic wand" and change the appearance of your smile, how would you like it look? _____		

## Sleep Evaluation

	Yes	No
Do you wake up feeling tired after a full night sleep?	<input type="checkbox"/>	<input type="checkbox"/>
Do you snore?	<input type="checkbox"/>	<input type="checkbox"/>
Does your spouse snore?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with sleep apnea?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, are you currently wearing a sleep device?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, are you happy with this treatment?	<input type="checkbox"/>	<input type="checkbox"/>

## Oral Cancer

Oral Cancer is on the rise, and last year 34,000 Americans were diagnosed with oral or pharyngeal cancer. On average it will cause over 8,000 deaths, killing 1 person per hour, 24 hours a day. Of those 34,000 newly diagnosed individuals, only half will survive 5 years. The death rate of oral cancer is higher than that of other cancers which we hear about routinely such as cervical cancer, Hodgkins lymphoma, laryngeal cancer, cancer of the testes, even skin cancer. The alarming mortality rate associated with this disease is due to the lack of early detection. If oral cancer is detected early it is completely treatable.

The good news is we can detect the early signs of oral cancer with a Velscope oral cancer screening today. It is pain-free and only takes a few minutes. It is the best tool we have to help detect the early signs of oral cancer. The cost for this service is \$35 and may be covered by your insurance company. Please initial below:

\_\_\_\_\_ I have been informed regarding the risk of oral cancer and I wish to have the Velscope oral cancer screening today.

\_\_\_\_\_ I have been informed regarding the risk of oral cancer but I do NOT wish to have the Velscope oral cancer screening today.

Forney Family Dentistry Office and Financial Policies

This is an outline of our office financial policies. We ask that you provide any/all insurance information to us upon arrival of your first visit. While we will do our very best to outline your insurance plan to you, it is ultimately your responsibility to know your insurance plan benefits and restrictions. Based upon the information given to us by your insurance plan, we will ask for co-payments accordingly. It is important to remember that your insurance policy is a contract between you and your insurance company. We will do everything possible to assist you in getting your claim paid: however, all charges incurred for your dental treatment are your sole financial responsibility. Your co-payments are an estimate only. The quotes given to our office by your insurance company are merely that. They are not a guarantee of payment to us. We ask that you pay your co-payment, deductible, or any balances at the time services are rendered. If you are unable to pay your estimated portion for that time, we ask that you make prior financial arrangements with our billing representative.

If you do not have dental insurance, by signing this statement you acknowledge that you understand that you are responsible for payment in full at the time services are rendered. If you have insurance, by signing this statement you acknowledge that your insurance company may pay less than the actual bill for services and that you are fully responsible for payment of your account. By signing this statement you agree to pay for all balances not paid by your insurance company and any legal fees incurred to enforce this statement. If a balance on any account is not paid within 30 days, you could be charged interest on that account until paid in full.

I hereby authorize the release of any information relating to insurance claims and I authorize payment of my group benefits directly to Melina Cozby, DDS and Forney Family Dentistry P.A. I agree to give Forney Family Dentistry permission to contact me regarding appointments and/or treatment at the phone number provided.

I certify that the information I provided here is true and correct

Signature \_\_\_\_\_ Date: \_\_\_\_\_

---

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Employee Signature : \_\_\_\_\_