Today's Date ___/___/____

Marion Dental Group

New Patient Acquaintance Form

Patient Name: _____ Birth Date: _____/_____/_____ Sex: M ○ F ○
Name of Parent (If Child), Guardian or POA: _____
Home Phone: ( ) _____ - _____ Cell: ( ) _____ - _____ Other: ( ) _____ - _____
Employer: _____ Work Phone: ( ) _____ - _____ EXT _____
Marital Status: S ○ M ○ D ○ W ○ Soc Sec Number:_____-____-_____ Dr License #:_____
Email: _____
Permanent Address: _____City: _____St: _____ Zip: _____

Temporary Address: _____ City: _____St: _____ Zip: _____

Family Doctor:_____ Phone: ( ) _____ - _____

Are you taking a blood thinner? Y ○ N ○ Name of Medication: _____
Have you had any knee, hip, or other bone replacements? Y ○ N ○ Dates: _____
Has a physician ever informed you to take an antibiotic prior to dental treatment? Y ○ N ○
Explain: _____
Any history of taking medications for Osteoporosis? Y ○ N ○ Any history of Chemotherapy? Y ○ N ○
If female, are you pregnant or nursing? Y ○ N ○
Are you allergic to any of these medications? Y ○ N ○
Penicillin ☐ Codeine ☐ Erythromycin ☐ Tetracycline ☐ Acetaminophen ☐ Clindamycin ☐ Cephalexin ☐
Are you allergic to Latex: Y ○ N ○
Do you have any other allergies? _____

List all medications or present a medication list to the receptionist:
_____
_____

Have you had any of the following? (Please Check)

AIDS/HIV	☐	**Emphysema**	☐	**Hepatitis A, B, C**	☐	**Prolapsed Mitral Valve**	☐
Asthma	☐	**GI/Stomach Ulcers**	☐	**High Blood Pressure**	☐	**Rheumatic Heart Disease**	☐
Cancer	☐	**Glaucoma**	☐	**Leaky/Regurgitating Valves**	☐	**Seizures/Epilepsy**	☐
Chest pain on exertion	☐	**Heart Attack**	☐	**Liver/Kidney Problem**	☐	**Shortness of Breath**	☐
COPD	☐	**Heart Murmur**	☐	**Low Blood Pressure**	☐	**Stroke**	☐
Coronary Insufficiency	☐	**Heart Stent(s)**	☐	**Organ Transplant _____**	☐	**Tuberculosis**	☐
Diabetes	☐	**Heart Valve Replacement**	☐	**Pacemaker**	☐	**Venereal Disease**	☐

Do you have any other medical concerns that you would like us to know about? Y ○ N ○
Explain: _____

Emergency Contact: _____ Phone: ( ) _____ - _____

DO YOU HAVE DENTAL INSURANCE? Y ○ N ○ Name of Insurance Company: _____

I understand that payment is expected at the time of service unless you agree to file my insurance. If however, after 90 days my insurance has not paid my claim, I will be expected to pay my balance in full for services rendered to me. I understand that if my account is placed for collection, a fee of 35% of the balance due or 5% interest will be added to my account, whichever is greater. I authorize Marion Dental Group to contact me at home or work to discuss any matter related to this form or any dental treatment. I have read the conditions stated relating to treatment and payment, and I agree to their content.

_____ **Date: ____/____/_____**
Signature of Patient, Guardian, or POA

Whom may we thank for your referral? _____