

# *Acquaintance Forms*

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*Welcome!  
From the Office of  
David R. Seguin, DDS, FAGD*

*Please take the time necessary to accurately fill out the following pages.*

*The more we know about you, the better we will be able to serve you.*

*Fellow, Academy of General Dentistry*

Welcome to our practice. Our goal is to help you achieve and maintain optimum oral health for a lifetime. So that we may best serve you, please complete these forms before your initial appointment with our office. We appreciate the confidence you've placed in us by selecting our team of dental professionals. We will continue to warrant that trust as we serve your dental needs.

Date \_\_\_\_\_

Name \_\_\_\_\_ Legal Name \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Email \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_

D.O.B. \_\_\_\_\_ SSN \_\_\_\_\_

Insurance Name \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Insured \_\_\_\_\_ D.O.B. \_\_\_\_\_ SSN \_\_\_\_\_

Insured Employer \_\_\_\_\_ Insurance Address \_\_\_\_\_

Who may we thank for referring you to our practice? \_\_\_\_\_

Previous Dentist \_\_\_\_\_ Phone \_\_\_\_\_ Date of last visit \_\_\_\_\_

Treatment Rendered \_\_\_\_\_ Shall we contact your last dentist for applicable records?  No  Yes

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

**PAYMENT POLICY:** Payment is requested at the time services are rendered. As a courtesy, we will file claims with most primary insurance companies and accept assignment of benefits, however **the patient or guardian is ultimately responsible for payment of all services rendered.** Late fees may be assessed to unpaid balances.

I understand and agree that any credit granted shall be paid promptly in accordance with terms and agreements and in the event of default to pay reasonable collection charges and/or attorney fees.

To the best of my knowledge, all preceding answers are true and correct; I will inform your office of any changes at my next appointment.

**Consent for Treatment:**

1. I hereby authorize Dr. Seguin or designated staff to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of dental needs. I authorize the use of digital photography and its use for patient education purposes.
2. Upon such diagnosis, I authorize Dr. Seguin to perform recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medications necessary. I fully understand that using local anesthetics embodies certain risks. I understand that I may ask for a complete recital of any possible complications. I agree that treatment may include root canal therapy, crowns or other types of restoration. I understand I may ask for a complete recital of all the possible benefits and risks of any dental treatment.

I have been given access to a copy of the Health Information Privacy Practices Act.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Guardian

# Dental Questionnaire

Last

First

Middle

Nickname

Correct answers to the following questions will allow us to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. Are you having any discomfort at this time?.....  Yes  No
2. Do you have any concerns about your teeth or gums at this time?.....  Yes  No  
If yes, explain: \_\_\_\_\_
3. Have you ever had any serious trouble associated with previous dentistry?.....  Yes  No
4. Does dental treatment make you nervous?  No  Slightly  Moderately  Extremely
5. Date of last dental visit? \_\_\_\_\_
6. Have you ever been treated for periodontal disease?.....  Yes  No  
(gum disease, pyorrhea, trench mouth)?
7. How often do you brush? \_\_\_\_\_ Brush is  Soft  Medium  Hard
8. Do you have or have you ever had any of the following:

## MOUTH

- Bleeding, sore gums  Yes  No
- Unpleasant taste/bad breath  Yes  No
- Burning tongue/lips  Yes  No
- Frequent blister, lips/mouth  Yes  No
- Swelling/lumps in mouth  Yes  No
- Ortho treatments (braces)  Yes  No
- Biting cheeks/lips  Yes  No
- Clicking/popping jaw  Yes  No
- Difficulty opening or closing jaw  Yes  No

## TEETH

- Loose teeth  Yes  No
- Sensitive to hot  Yes  No
- Sensitive to cold  Yes  No
- Sensitive to sweets  Yes  No
- Sensitive to biting  Yes  No
- Food impaction  Yes  No
- Clenching/grinding  Yes  No
- If so, when
- Shifting in bite/Change in bite  Yes  No

9. Do you use the following?  
Brush  Yes  No  
Fluoride rinse  Yes  No  
Dental floss  Yes  No  
Other  \_\_\_\_\_

These are the things that are important to me about my dental health: \_\_\_\_\_

What do you fear most about dental care? \_\_\_\_\_

Circle One:

1. My mouth is  
a) very comfortable  
b) moderately comfortable  
c) uncomfortable
2.  
a) I think the appearance of my mouth is excellent.  
b) I am satisfied with the appearance of my mouth  
c) I am dissatisfied with the appearance of my mouth.
3.  
a) I will do anything to keep my natural teeth  
b) I want to keep my teeth, but have a certain budget of time and money that I am willing to spend.
4.  
a) I have set goals for my oral health with a previous dentist.  
b) I want to set goals concerning my dental health.
5.  
a) I have always done the best that was recommended for my dental health.  
b) I have not done what dentists have recommended.  
c) I rarely go, and don't care much about having my dental work completed.
6.  
a) I have put dentistry for myself and family high on my priority list.  
b) I put dentistry for myself and my family low on my priority list.  
c) Dentistry is on my list, but it's hard to find.
7. I think my present state of dental health is  
a) Excellent  
b) Good  
c) Poor

What are some questions about dentistry and oral health that you have never had adequately answered?

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# Medical Questionnaire

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Correct answers to the following questions will allow us to treat you so there **WILL NOT** be an emergency. However, if an emergency situation does arise, this information will help insure proper treatment. As before, your answers are for our records only and will be considered confidential.

Do you have or have you ever had:

Anemia  Yes  No

Diabetes  Yes  No

Allergies

To penicillin  Yes  No

To local anesthetic  Yes  No

Other \_\_\_\_\_  Yes  No

Abnormal heart condition  Yes  No

Artificial heart valve/pacemaker  Yes  No

Abnormal bleeding from a cut  Yes  No

Rheumatic fever/mitral valve prolapse  Yes  No

Are you under the care of a physician now?  Yes  No

(Women) Are you pregnant/or nursing?  Yes  No

Are you taking any medication?  Yes  No

If Yes, What? \_\_\_\_\_

Any other medical conditions? \_\_\_\_\_

Do you smoke or have you smoked in the past?  Yes  No

Have you ever been hospitalized or had a serious illness in the last five years, if so explain:

\_\_\_\_\_  
\_\_\_\_\_

Date of last medical examination \_\_\_\_\_

Name of Physician \_\_\_\_\_

Other physical conditions \_\_\_\_\_

Name of nearest relative \_\_\_\_\_

Phone number \_\_\_\_\_

**BLOOD PRESSURE** \_\_\_\_\_ **Date** \_\_\_\_\_