

G. PETE LESEBERG, D.M.D., P.A.
ORAL AND MAXILLOFACIAL SURGERY
DIPLOMATE, AMERICAN BOARD OF ORAL AND MAXILLOFACIAL SURGERY
1550 N. CRESTMONT DR., SUITE G • MERIDIAN, ID 83642
(208) 884-0100 • FAX (208) 884-4844

ACQUAINTANCE FORM

PATIENT INFORMATION - PLEASE PRINT CLEARLY

Today's Date _____
Mr. Mrs.
Miss Ms. _____ Date of Birth _____
Address _____ Apt. # _____ City _____ State _____ Zip _____
Home Phone () _____ Work Phone () _____ Cell () _____
Social Security Number _____ Age _____ Driver's License Number _____
Name of Physician _____ Physician's Phone _____
Name of General Dentist _____ Referred by _____

FINANCIAL PARTY INFORMATION (IF PATIENT IS A MINOR)

Name _____ Relationship _____
Address _____ Apt. # _____ City _____ State _____ Zip _____
Home Phone () _____ Work Phone () _____
Social Security Number _____ Date of Birth _____ Driver's License Number _____
Place of Employment _____

EMPLOYMENT INFORMATION (IF DIFFERENT FROM FINANCIAL PARTY)

Name of Employer: _____ Address: _____
Employer Phone #: () _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Do you have Dental Insurance ? Yes No Name of Insurance _____
Insurance Address _____ Suite # _____ City _____
State _____ Zip _____ Insurance Phone () _____
Policy Number _____ Group/Local Number _____
Subscriber/First _____ Middle _____ Last _____
Social Security Number _____ Date of Birth _____
Address _____ Apt. # _____ City _____ State _____ Zip _____
Employer _____ Employer Phone () _____
Employer Address _____ City _____ State _____ Zip _____

OTHER DENTAL YES NO - IF YES, COMPLETE THE FOLLOWING

Name of Insurance _____ Policy Number _____
Subscriber/First _____ Middle _____ Last _____
I.D. Number _____ Date of Birth _____
Insurance Address _____ City _____ State _____ Zip _____
Employer _____ Phone () _____

HEALTH HISTORY

Answer all questions by circling Yes (Y) or No (N) – All responses are kept confidential

- | | |
|--|---|
| <p>1. Are you in good health? Y N</p> <p>2. Has there been any change in your general health in the past year? Y N</p> <p>3. Date of last physical exam _____</p> <p>4. Are you now under a physician's care for a particular problem? Y N</p> <p>5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe. Y N</p> <p>_____</p> <p>6. Height _____ Weight _____</p> <p>7. DO YOU HAVE OR HAVE YOU EVER HAD:</p> <p>A. Rheumatic Fever or Rheumatic Heart Disease? . . . Y N</p> <p>B. Congenital Heart Disease? Y N</p> <p>C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? Y N</p> <p>D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? Y N</p> <p>E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness? Y N</p> <p>F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? Y N</p> <p>G. Liver Disease (Jaundice, Hepatitis)? Y N</p> <p>H. Kidney Disease? Y N</p> <p>I. Diabetes? Y N</p> <p>J. Thyroid Disease (Goiter)? Y N</p> <p>K. Arthritis? Y N</p> <p>L. Stomach Ulcers or Colitis? Y N</p> <p>M. Glaucoma? Y N</p> <p>N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? Y N</p> <p>O. Radiation (X-ray) treatment for Cancer? Y N</p> <p>P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? . . . Y N</p> <p>Q. Sinus or Nasal problems? Y N</p> <p>R. Any disease, drug or transplant operation that has depressed your immune system? Y N</p> <p>8. ARE YOU USING ANY OF THE FOLLOWING:</p> <p>A. Antibiotics? Y N</p> <p>B. Anticoagulants (Blood Thinners)? Y N</p> <p>C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? . . Y N</p> <p>D. High Blood Pressure medications? Y N</p> <p>E. Steroids (Cortisone, etc.)? Y N</p> <p>F. Tranquilizers? Y N</p> <p>G. Insulin or Oral Anti-Diabetic drugs? Y N</p> | <p>H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N</p> <p>I. Are you taking or <i>have you ever taken</i> Bisphosphonates (Fosamax, Actonel or Boniva for osteoporosis, Aredia or Zometa for various cancers, etc.)? Y N</p> <p>J. Please list any and all medications taken, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:_____</p> <p>_____</p> <p>9. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:</p> <p>A. Local Anesthesia (Novocaine, etc.)? Y N</p> <p>B. Penicillin or other antibiotics? Y N</p> <p>C. Sedatives, Barbiturates? Y N</p> <p>D. Aspirin or Ibuprofen? Y N</p> <p>E. Codeine or other pain killers? Y N</p> <p>F. Latex or Rubber Products? Y N</p> <p>G. Other allergies or reactions? Please list. Y N</p> <p>_____</p> <p>10. Do you smoke or chew Tobacco? Y N
How much per day? _____</p> <p>11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? Y N</p> <p>12. Have you had any serious problems associated with any previous dental treatment? Y N</p> <p>13. Have you or an immediate family member had any problem associated with intravenous anesthesia? . . . Y N</p> <p>14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Y N</p> <p>15. Do you wish to talk to the doctor privately about anything? Y N</p> <p>16. FOR WOMEN ONLY</p> <p>A. Are you Pregnant, or is there any chance you might be Pregnant? Y N</p> <p>B. Are you nursing? Y N</p> <p>C. If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.</p> <p>BP: _____ / _____ HR: _____ Temp: _____</p> |
|--|---|

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible.

Date	Signature of Person Completing Health History	Doctor's Initials
------	---	-------------------

Medical Update: I have read my Health History dated _____ and confirm that it adequately states past and present conditions.

Date	Exceptions or changes	Patient's Signatures	Doctor's Initials
------	-----------------------	----------------------	-------------------

Date	Exceptions or changes	Patient's Signatures	Doctor's Initials
------	-----------------------	----------------------	-------------------