Stephen R. Torgerson, D.D.S.
Patient Acquaintance Form

Name _____ Birthdate _____
Address _____ City _____ State ____ Zip Code _____
Home Phone _____ Cell Phone _____ Work Phone _____
Email Address: _____ Nickname: _____
Do you prefer contact via email or phone call? _____
Marital Status _____ Spouse/Significant Other Name _____
Name of Responsible Party: (**Self If Adult**) _____
Billing Address (If Different From Home Address) _____
Primary Subscriber Name _____ Birthdate _____
Employer _____ Occupation _____
Dental Insurance Carrier _____ Group Number_____
ID Number _____ Social Security Number _____
Secondary Dental Insurance (Y/N) If Yes, Employer_____
Secondary Subscriber Name _____ Birthdate _____
Secondary Dental Insurance ID Number_____ _____Social Security Number_____
Group Number_____
Whom may we thank for referring you to our office? _____

DOES YOUR MEDICAL HISTORY INCLUDE ANY OF THE FOLLOWING?

- Allergy to **local anesthetics** ..... Yes No
- Allergy to **sulfa drugs** ..... Yes No
- Allergy to **codeine** ..... Yes No
- Allergy to **penicillin** ..... Yes No
- Allergy to **latex** ..... Yes No
- Any other allergies _____
  _____
- Have you been hospitalized or had surgery in the last 5 years? ..... Yes No
- If so please explain _____

Heart Surgery	Yes No	Chest Pain	Yes No	Heart Murmur	Yes No
Congenital Heart Disease	Yes No	Diabetes	Yes No	Stroke	Yes No
Artificial Heart Valve	Yes No	Hepatitis	Yes No	Tuberculosis	Yes No
High Blood Pressure	Yes No	Glaucoma	Yes No	Cancer	Yes No
Low Blood Pressure	Yes No	Emphysema	Yes No	Tumors	Yes No
Thyroid Disorders	Yes No	Chemotherapy	Yes No	Sleep Apnea	Yes No
Radiation Therapy	Yes No	AIDS	Yes No	HIV Positive	Yes No
Mitral Valve Prolapse	Yes No	Asthma	Yes No	Liver Disease	Yes No
Rheumatic Fever	Yes No	Epilepsy	Yes No	Hemophilia	Yes No
Venereal Disease	Yes No	Pacemaker	Yes No	Artificial Joints	Yes No

- Have you ever taken Fen-Phen (diet aid)..... Yes No
- Have you ever taken Bisphosphonates? (for osteoporosis)..... Yes No
- Are you pregnant or nursing?..... Yes No
- Are you taking birth control medications? ..... Yes No
- Does dental treatment make you nervous? No Slightly Moderately Extremely
- Please list all medications or provide us with a list we can copy

_____

_____

- Are there any other conditions you feel we should be aware of?

_____

_____

- Physicians Name: _____ Phone Number _____
- Pharmacy Name: _____ Phone Number _____

- Emergency Contact: _____ Phone Number _____
  Relationship: _____

Dental Health Information

- Name of Previous Dentist: _____ Phone Number _____
- Last Dental Visit: _____ Last Dental X-rays: _____

Have you had any injuries/surgeries in the mouth/jaw area? Yes No
If yes, please explain: _____
Have you ever been informed that you had periodontal (gum) disease? …….. Yes No

Please provide us the name and relationship of those allowed access to your Protected Health Information:
_____
_____
_____

Consent For Treatment
I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy which may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems necessary. I also understand that prior to treatment; full explanations of the procedure(s) will be given by the doctor and/or his staff. I understand that I will be involved in the decision making process for my treatment.

I authorize the dentist and/or his staff to release information necessary to secure benefits from my dental insurance company and authorize my dental insurance company to pay such benefits directly to Dr. Torgerson. I understand I am responsible for payment of all services rendered on my behalf whether covered by insurance or not.

We appreciate your busy schedule and are committed to reserving our facilities and time just for you. Kindly notify our office at least 48 hours prior to your appointment should something arise preventing you from keeping the appointment. We will be happy to find another, more convenient time**.** I understand that Dr. Torgerson reserves the right to charge a fee of $50 for appointments missed or cancelled same day.

I have read and understand the information above and on the reverse side of this form and answered the questions accurately. I understand that providing false or misleading information may be detrimental to my overall health. I will not hold Dr. Torgerson or his employees responsible for any errors or omissions that I may have made on this form.

☐ I have received, or been offered, a copy of this office's **Notice of Privacy Practices**
☐ I have received, or been offered, a copy of the **Dental Materials Fact Sheet**

_____ _____
Signature of patient or patients legal guardian Date

UPDATES:

I have reviewed my health history and confirm that it accurately states past and present conditions and medications.

Form updated: _____ _____

Form updated: _____ _____

Form updated: _____ _____

Form updated: _____ _____