Daniel Barletta, D.M.D.
Patient Acquaintance Form

Name_____Address_____

City_____ State_____Zip_____Home Phone_____

Work Phone_____ Cell Phone_____email_____

Sex M/F____ Marital Status _____Birthdate _____Soc. Sec. #_____

Name of Responsible Party_____

Billing Address_____

Insurance Y__N__ Employer Name_____Phone_____

Insurance Company Name_____Insurance ID#_____

Referred By_____

Medical History

1. Are you under any Medical Treatment?.....___Yes___No
2. List drugs you are Presently taking_____

_____

4. Have you had any Major operations?_____

Has a Physician ever informed you that you had:

5. Any heart ailment?.....___Yes___No
6. Respiratory disease?.....___Yes___No
7. High Blood Pressure?...___Yes___No
8. Diabetes?.....___Yes___No
9. Rheumatic Fever?.....___Yes___No
10. HIV infection or Aids?.....___Yes___No
11. Any blood disease?.....___Yes___No
12. Any Liver disease?...……___Yes___No
13. Any Kidney disease?...…___Yes___No
14. Hepatitis?.....___Yes___No

15. Are You Allergic to any Medications (like Penicillin) _.....___Yes____No.

Please list Allergies_____
16.Women only. Are you Pregnant……___Yes___No

Dental History

17. Have you ever had Novocaine Anesthetic?.....…….…___Yes___No
18. Have you ever had any reactions or allergies to Novocaine?.....___Yes___No
19.Have you ever had instructions on the care of your gums?.....___Yes___No
20. or on the correct Method of brushing your teeth?.....___Yes___No
21. Do you at Present have any dental complaints…….___Yes___No

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Signature_____Date_____