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

Name: ________________________________ Address: __________________________________

City: ________________________ State: ____ Zip Code: _______ 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: ☐ Details: __________________________

2. List drugs you are presently taking: ____
____

3. Have you had any major operations? Yes: ☐ No: ☐ Details: ___________________________

4. Have you had any joint replacements; hip, knee, etc.? Yes: ☐ No: ☐ Details:_____________

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. HIV infection or Aids? Yes: ☐ No: ☐
10. Any blood disease? Yes: ☐ No: ☐
11. Any Liver, kidney disease? Yes: ☐ No: ☐
12. Any seizure disorder? Yes: ☐ No: ☐

13. Are you allergic to any medications? (like Penicillin) Yes: ☐ No: ☐

Please list Allergies: ____

14. Are you required to premedicate with antibiotics before your dental visit? Yes: ☐ No: ☐

Dental History

15. Have you ever had Novocaine Anesthetic? Yes: ☐ No: ☐
16. Have you ever had any reactions or allergies to Novocaine? Yes: ☐ No: ☐
17. Do you at present have any dental complaints? Yes: ☐ No: ☐

Details: ____

Signature: ____ Date: ______________________