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_____

2. List drugs you are presently taking _____

_____

3. Have you had any major operations?____Yes____No_____

4. Have you had any joint replacements –hip, knee, etc?___Yes___No_____

Has a Physician ever informed you that you had:

5. Any heart ailment?	___Yes___No	9. HIV infection or Aids?	___Yes___No
6. Respiratory disease?	___Yes___No	10. Any blood disease?	___Yes___No
7. High Blood Pressure?	___Yes___No	11. Any Liver, kidney disease?	___Yes___No
8. Diabetes?	___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

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Signature_____Date_____