

JONATHAN J.  
**GOLAB** D.D.S., P.A.

Cosmetic Reconstructive Dentistry

**PATIENT HISTORY AND ACQUAINTANCE FORM**  
 This Information is Important for Our Records and Your Health

Today's Date \_\_\_\_\_ Patients Name \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Residence Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Residence Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employed By \_\_\_\_\_ Email \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Referred By \_\_\_\_\_

Do you have any dental insurance? \_\_\_\_\_ Name of insurance company \_\_\_\_\_

Address of insurance company \_\_\_\_\_ Group No. \_\_\_\_\_

Name if insured party \_\_\_\_\_ Who will pay this account? \_\_\_\_\_























Marital Status      Single      Married      Widowed      Divorced      Separated

NAME IN FULL OF YOUR (HUSBAND, WIFE, PARENT) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employed by \_\_\_\_\_ Social Security Number \_\_\_\_\_

Employer's Address \_\_\_\_\_ Occupation \_\_\_\_\_

Your Physician's name \_\_\_\_\_ Phone Number \_\_\_\_\_

	<b>YES</b>	<b>NO</b>
How long since your last dental visit? _____		
Are you having any dental problems presently? .....		
If so, describe _____		
Have you ever had periodontal (gum) treatments? .....		
Are you interested in cosmetic dentistry (bleaching, etc.)? .....		
Have you ever had orthodontics (braces)? .....		
Do you brush your teeth regularly? .....		
Do you floss your teeth regularly? .....		
Do you grind or clench your teeth when you are nervous or sleeping? .....		
Do your jaws click or pop when you chew? .....		
Is there any other information we should know about your health or previous dental visits? .....		
If so, explain _____		
Have I ever treated any of your friends or family? .....		
If so, name? _____		
Have you ever been treated for TMJ (jaw) problems? .....		

I AUTHORIZE THE RELEASE OF ALL DENTAL INFORMATION ABOUT ME OR MY MINOR CHILDREN TO PHYSICIANS, HOSPITALS, INSURANCE COMPANIES AND DENTISTS.

SIGNATURE OF PATIENT (IF MINOR, PARENT SIGNS) \_\_\_\_\_ DATE \_\_\_\_\_

TURN OVER AND CONTINUE.....

