Joseph T. Luke, D.D.S., M.S.
Patient Acquaintance Form

Date_____ Home Phone (___)_____Cell Phone (___)_____Email _____

Whom may we thank for referring you?_____

PATIENT INFORMATION

Name_____SS#_____
Last Name First Name Middle Initial

Address_____

City_____State_____Zip_____

Sex ☐ M ☐ F Age_____Birth date_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By_____Occupation_____

Business Address _____Business Phone (___) _____

In case of emergency who should be notified? _____Phone (___)_____

PRIMARY DENTAL INSURANCE

Person Responsible for Account_____
Last Name First Name Middle Initial

Relation to Patient _____Birth date of insured _____SS#_____

Address (if different from patient's) _____Phone(___)_____

Person Responsible Employed By_____Occupation_____

Business Address _____Business Phone (___)_____

Insurance Company_____Contract #_____Group #_____Subscriber #_____

ADDITIONAL DENTAL INSURANCE

Is patient covered by additional dental insurance? ☐ Yes ☐ No

Subscriber Name_____Relation to Patient_____Birth date_____

Address _____Phone (___)_____

Subscriber Employed B _____Business Phone (___)_____

Insurance Company_____Contract #_____Group #_____Subscriber #_____

AUTHORIZATION

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____Date_____

Payment is due in full at time of treatment unless prior arrangements have been approved.

DENTAL HISTORY

Reason for Today's Visit_____ Date of last dental care_____

Former Dentist_____ Date of last dental x-rays_____

Please (X) if you have had problems with any of the following:

☐Bad breath	☐Grinding teeth	☐Sensitivity to hot
☐Bleeding gums	☐Loose teeth	☐Sensitivity to sweets
☐Clicking or popping jaw	☐Periodontal treatment	☐Sensitivity when biting
☐Food collection between teeth	☐Sensitivity to cold	☐Sores or growths in mouth

How often do you floss?_____ How often do you brush?_____

MEDICAL HISTORY

Are you under the care of a physician? ☐Yes ☐No For what conditions?_____
Name of physician_____ Date of last visit_____
Have you had any serious illnesses or operations? ☐Yes ☐No If yes, describe_____
Have you ever had a blood transfusion? ☐Yes ☐No If yes, give approximate dates_____
(Women) Are you pregnant? ☐Yes ☐No If yes, give Due Date_____

Please (X) if you have or have had any of the following:

Anemia	Arthritis, Rheumatism	Artificial Heart Valves	Artificial joints
Asthma	Back problems	Blood Disease	Chemical Dependency
Chemotherapy	Circulatory Problems	Cortisone Treatments	Cough up Blood
Diabetes	Epilepsy	Fainting	Headaches
Heart Murmur	Heart Problems	Hepatitis	High Blood Pressure
HIV/AIDS	Kidney Disease	Liver Disease	Mitral Valve Prolapse
Pacemaker	Psychiatric Treatment	Radiation Treatment	Respiratory Disease
Rheumatic Fever	Shortness of Breath	Skin Rash	Stroke
Swelling of feet & ankles	Thyroid Problems	Tobacco Habit	Cancer
Tuberculosis	Ulcer	Venereal Disease	Jaw Pain

MEDICATIONS: List medications you are currently taking:

ALLERGIES

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐Yes ☐No

Have you ever responded adversely to medical or dental treatment? ☐Yes ☐No If so, how_____

Is there anything else we should know about your medical history?_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I any have made in the completion of this form.

Date_____ Signature_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE: Please Initial _____