ACQUAINTANCE FORM

Today's Date_____Please give us some information…….
Email_____

About You:

Dr. Mr. Mrs. Ms. Miss _____
First Mi Last
I Prefer to be Called:_____Birthdate_____Age_____
I am: Single Married Divorced Separated Widowed
Home Address:_____City:_____ST:_____Zip:_____
Mailing Address:_____City:_____ST:_____Zip:_____
Phone:_____
Home Work Pager or Cell Phone
Driver's License #:_____Soc.Sec. #:_____
Employer:_____
Name Address City ST Zip
Your Occupation:_____
WHO MAY WE THANK FOR REFFERING YOU:_____

About Your Spouse or Parent/Guardian:

Name:_____Birthdate:_____
Address:_____Phone #:_____
Driver's License #:_____Soc. Sec. #:_____
Employer:_____
Name Address Phone #
Occupation:_____

About Your Dependents if Applicable:

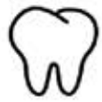
Name:_____Age:_____ Name:_____Age:_____
Name:_____Age:_____ Name:_____Age:_____

About Your Dental Insurance:

<u>Primary Dental Insurance</u>
Insurance Co:_____
Name Mailing Address City St Zip
Phone:_____Group #, Plan or Policy #:_____Effective Date:_____
Insured's Name:_____Relation:_____
Insured's SS#:_____D.O.B:_____Employer:_____
<u>Secondary Dental Insurance</u>
Insurance Co:_____
Name Mailing Address City St Zip
Phone:_____Group #, Plan or Policy #:_____Effective Date:_____
Insured's Name:_____Relation:_____
Insured's SS#:_____D.O.B:_____Employer:_____

Signature of Patient or Responsible Party_____Date_____

WE APPRECIATE REFFERALS FROM FAMILY AND FRIENDS



ANITA M. PAULUS, D.D.S., P.C.
FAMILY & COSMETIC DENTISTRY

Assignment of Insurance Benefits to Dentist

I agree to assign benefits from my insurance company to Anita M. Paulus, D.D.S., P.C. in the course of dental treatment in her office. The treatment and financial plans have been explained and presented to me and the insurance company's portion has been estimated. I understand that after the insurance company has paid their portion to the doctor, the remaining amount (known as the co-payment) is due and payable to Anita M. Paulus, D.D.S., P.C. I agree to assign benefits to Anita M. Paulus, D.D.S., P.C. from the date of signature below indefinitely.

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Please Print Name: _____ Signature: _____ Date: _____

With whom may we discuss treatment?

Please Print Name: _____ Signature: _____ Date: _____

Method of Contact

Our office sends reminder cards, makes phone calls, sends emails and text messages and leaves messages for appointments. We will also talk to necessary doctors and dentists about your treatment. I understand this method of communication and consent to it.

Please Sign _____ Date: _____

4901 BYERS
FORT WORTH, TEXAS 76107
817-738-2163

Health History

Patient Name:_____

Physician's Name:_____ **Date of last Physical Exam:**_____

In case of Emergency, notify:_____ **Phone:**_____

Nearest Relative:_____ **Phone:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Do you have or have had any of the following? Please Circle Yes or No

Hypoglycemia, Diabetes	Yes/No	Aids Exposure	Yes/No	Heart Attack, Heart Trouble	Yes/No
Circulatory Problems	Yes/No	Hay Fever, Asthma	Yes/ No	Mitral Valve Prolapse	Yes/No
Excessive Bleeding	Yes/No	Epilepsy, Seizers	Yes/No	Artificial Heart Valves	Yes/No
Anemia, Blood Disorder	Yes/No	Hepatitis, Jaundice	Yes/No	Heart Murmur	Yes/No
Lung Problems	Yes/No	Fainting, Blackouts	Yes/No	Artificial Joints	Yes/No
Nervous Disorder	Yes/No	Blood Transfusion	Yes/No	High Blood Pressure	Yes/No
Facial or Head Injuries	Yes/No	Kidney Problems	Yes/No	Rheumatic Fever	Yes/No
Glaucoma, Eye Problems	Yes/No	Malignancies, Cancer	Yes/No	Ulcer, Digestive Problems	Yes/No
Sinus Problems	Yes/No	Are you Pregnant?	Yes/No	Stroke	Yes/No
Headaches, Migraines	Yes/No	Radiation Treatment	Yes/No	Thyroid Problems	Yes/No
Heart Pacemaker	Yes/No	Other	Yes/No	Drug Use	Yes/No

Have you been hospitalized in the last 2 years?_____ **If yes please Explain**_____

_____

Have you have unfavorable reactions to any of the following. Please circle Yes or No

Aspirin: Yes/No Codeine: Yes/No Anesthetics: Yes/No Novocaine: Yes/No

Sedatives: Yes/No Sulfa: Yes/No Penicillin: Yes/No Other: Yes/No

Please list any medications you are currently taking:_____

_____

Date of last dental visit_____ **Date of last cleaning**_____ **Date of last set of full x-rays** _____

Name of last Dentist_____ **Phone**_____ **May we have records released Yes/No**

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

Do you smoke/Chew tobacco? Yes/No how often_____ **Do You Drink alcohol? Yes/No How often**_____

Do you Snore? Yes/No

Have you noticed any of the following? Please Circle Yes or No

Loss of teeth?	Yes/No	Teeth tender to chew on?	Yes/No	Discomfort in face, head or neck?	Yes/No
Bleeding Gums?	Yes/No	Food caught between teeth?	Yes/No	Sensitivity to sweets?	Yes/No
Grinding teeth?	Yes/No	Hot and cold sensitivity?	Yes/No	Jaw clicking or popping?	Yes/No
Sores in mouth?	Yes/No	Swelling, or lumps in mouth?	Yes/No	Do you clench your teeth?	Yes/No

Have you ever had periodontal treatment (deep cleaning)? Yes/No If yes how long ago?_____

Have you ever had any problems with dental treatment? Yes/No If yes, How long ago?_____

The Information above is correct to the best of my knowledge. I give consent to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. I also authorize the doctor and her staff to perform dental treatment indicated by the diagnosis.

_____ _____

Signature of Patient or Parent/ Guardian **Date**

_____ _____

Anita Paulus, D.D.S., P.C. (Dentist) **Date**

Blood pressure_____ **Pulse**_____ **Date**_____ **Initials**_____

Oral Cancer Screen Date_____ **Initials**_____

ASA Classification_____ **Date**_____ **Initials**_____

Office Information

Our Mission: to provide our patients with state of the art dentistry of the highest quality in a friendly, caring environment

About the Dentist: Dr. Anita Paulus received her dental degree from Baylor College of Dentistry in Dallas, TX in 1990. She is married to an orthodontist, William Paulus and together they have two daughters. She has had several opportunities to work with other dentist and through this has gained valuable experiences. Anita believes in the highest quality of care and giving the best treatment available. She has had very high level of training in cosmetic dentistry from the most up to date practitioners. Aside from cosmetic dentistry, she offers all aspects of general dentistry. Dr. Paulus truly enjoys meeting her patients and working with them to get the best results possible.

About our Staff: Our staff is a caring, dedicated team and we are looking forward to helping you with your dental experience. Our goal is to provide you with a warm, gentle atmosphere, so that your visit to the office is as comfortable as possible.

Our Services: Family Care, Cosmetic Dentistry and Smile Enhancement. Restorative Dentistry, Crowns and Bridges, Tooth-colored fillings, Root Canals and Extractions. Dental Implants, Teeth Whitening and Bleaching (including our in office instant 45 minute teeth whitening treatment). Periodontal Therapy, Surgical and non-surgical options, the highest standard of sterilization, Imaging, Soft Tissue Laser, Nitrous Oxide (laughing gas) and Intra Oral Camera.

Office Hours: The office is open Monday, Tuesday and Wednesday 8:00am to 4:00pm and Fridays from 8:00am to 4:00pm or by appointment.

Financial Arrangements: In addition to making the dentistry comfortable, we work hard to make the financing comfortable! We have credit approved financing for your dentistry (Care Credit and Chase Health Finance). Give us a chance to help you find the plan that is best for you. Payment is due at the time services are rendered. Balances older than 90 days are subject to finance charges of 18.9%. In addition to cash and checks, we accept Visa, MasterCard, American Express and Discover. Insurance will be filled as a courtesy.

Dr. Paulus and her staff will make every effort to begin treatment at your appointment time; however, dental emergencies do occur frequently. When this happens we ask for your understanding. If this causes problems with your schedule, please feel free to reschedule your appointment. *If you find that you cannot keep your appointment, kindly notify the office within 24 hours of your appointment.*

We are happy to treat children of any age. We recommend that children have their first dental examination between their third and fourth birthdays. CHILDREN MUST BE ACCOMPANIED BY AN ADULT AT ALL TIMES WHILE IN THE RECEPTION AREA.

_____

Signature Date