ACORN Dental Clinic

Name: _____ Date: ____/____/____
(Last) (First) (M. Init)

Sex: M / F Race: _____ Language: _____

Birth Date: _____/_____/_____ Age:_____ Social Security: _____

Address: _____ City: _____
(Street) (Apt. #)

State: _____ Zip: _____County_____

Driver's license #: _____

Medicaid #: _____

Please circle one: Employed Unemployed Retired Disabled

How did you hear about ACORN? Family/Friend Media School Church Outreach

Doctor/Dentist Other_____

Home Phone: (_____) _____ - _____ Work: (_____) _____ - _____ * _____

Cell Phone: (_____) _____ - _____ Email: _____

How many people in household _____

Total Monthly Household Income (from all sources-including child support): _____

Emergency Contact: _____ Phone: (_____) _____ - _____

Parent's Name **(if minor)** _____

Physician's name: _____ City: _____

Phone: (_____) _____ - _____ Date of last visit: _____/_____/_____

Pharmacy: _____ Pharmacy Phone #:_____

Continued on back

Name _____

(Circle **Y** or **N** to indicate if have ever had any of the following):

Acid Reflux/GERD	**Y**	**N**	Herpes	**Y**	**N**
AIDS / HIV	**Y**	**N**	High Blood Pressure	**Y**	**N**
Alcohol Dependency	**Y**	**N**	Jaundice	**Y**	**N**
Anemia	**Y**	**N**	Kidney Disease	**Y**	**N**
Arthritis, Rheumatism	**Y**	**N**	Liver Disease	**Y**	**N**
Artificial Heart Valves	**Y**	**N**	Mental Disorders/Psychiatric Care	**Y**	**N**
Artificial Joint	**Y**	**N**	Mouth Sores	**Y**	**N**
Asthma	**Y**	**N**	Nervous Disorders	**Y**	**N**
Bleeding Abnormally / Excessive	**Y**	**N**	Pacemaker	**Y**	**N**
Bleeding gums	**Y**	**N**	Past Surgeries	**Y**	**N**
Blood Disease	**Y**	**N**	Radiation	**Y**	**N**
Cancer	**Y**	**N**	Respiratory Disease	**Y**	**N**
when & type:			Rheumatic Fever	**Y**	**N**
Chemical/Drug	**Y**	**N**	Seasonal Allergies	**Y**	**N**
Chemotherapy	**Y**	**N**	Shortness of Breath	**Y**	**N**
Clenching, Grinding, Jaw Popping	**Y**	**N**	Sinus Trouble	**Y**	**N**
COPD/Emphysema	**Y**	**N**	Sleep Apnea	**Y**	**N**
Diabetes	**Y**	**N**	Stroke	**Y**	**N**
Dry Mouth	**Y**	**N**	Swollen feet and ankles	**Y**	**N**
Epilepsy	**Y**	**N**	Teeth Sensitivity	**Y**	**N**
Fainting/Dizziness	**Y**	**N**	Thyroid Problems	**Y**	**N**
Head/Neck/Back Injury	**Y**	**N**	Tobacco Use	**Y**	**N**
Heart Attack	**Y**	**N**	Tuberculosis	**Y**	**N**
Heart Disease	**Y**	**N**	Tumor	**Y**	**N**
Heart Murmur	**Y**	**N**	Ulcer	**Y**	**N**
Hepatitis, ***type***:	**Y**	**N**	Venereal Disease	**Y**	**N**

Have you ever been told to take medication before a dental procedure? **Y / N**

Type:_____

List any medication allergies: _____

List all medications you are currently taking: _____

_____

_____

Are you taking or have you ever taken medication for bone density?_____

WOMEN:

Are you pregnant? ____ Due Date: _____/_____/_____Are you nursing? _____

Are you taking birth control pills? _____

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