Tampa Dental-Acquaintance Form
Laz N. Kavouklis, D.M.D or Nick L. Kavouklis, D.D.S.

Welcome to our office. We do our best to make your appointments as convenient as possible. If at any time you have questions regarding your treatment, appointment, or fees, please feel free to ask. This "Acquaintance Form" will help us serve you better.

PLEASE PRINT **Date** ______________________

Mr./Mrs./Ms. /Dr.____

Last Name **First Name** **Middle Initial**

□ **Minor** □ **Single** □ **Married** □ **Widowed** □ **Divorced** □ **Separated**

If child, parent's full name ______________________________________

Residence Address ______________________________________

City ____________________ **State** __________ **Zip** ______________ **Date of Birth** ________________

Home Phone ________________**Cell Phone** ________________ **Email** ____________________

Occupation ______________________ **Employer** ______________________________

Business Address ______________________ **Work Phone** ________________ **Ext.** __________

Do you have dental insurance? __________ **If yes, what is the name of your insurance company** ________________

Group Number ____________ **SS #** ________________ **Driver's License Number** ________________

Please tell us whom we may thank for referring you to our office. ______________________

Has any member of your family ever been treated in our office? ____________ **If yes, whom?** ________________

Dental History

What is the purpose of your visit today? ______________________________

Has fear of discomfort kept you from regular visits? ______________________

Describe ______________________________________

How long has it been since your last dental appointment? ______________________

Do you prefer nitrous oxide sedation (tranquilizing air) during treatment? ______________________

How would you describe your present dental health? □ **Good** □ **Fair** □ **Poor**

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

□ **Bad breath**
□ **Bleeding gums**
□ **Clicking or popping jaw**
□ **Food collection between teeth**
□ **Grinding teeth**
□ **Loose teeth or broken fillings**
□ **Periodontal treatment**
□ **Sensitivity to cold**
□ **Sensitivity to heat**
□ **Sensitivity to sweets**
□ **Sensitivity when biting**
□ **Sores or growths in mouth**

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

(Form revised-July, 2008)