

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Welcome

Dennis W. Stoll, D.D.S., Inc.
Patient Acquaintance Form

Date _____

Name _____ Address _____

City, State, Zip _____ Home Phone _____

Work Phone _____ Sex (M/F) _____ Marital Status _____ Birthdate _____ SSN # _____

Name of Responsible Party _____ Billing Address _____

Insurance (Y/N), Name _____ Address/Phone _____

Employer _____ Address (City, St, Zip) _____ Phone _____

Referred By _____

Name of Relative/Friend (not at same address) _____ Telephone No.: _____

Does Your Medical History Include Any Of The Following:

- | | | |
|---|--|---|
| 1. Is your general health good | Y | N |
| 2. Are you under any Medical Treatment? If yes, for what? _____ | Y | N |
| 3. Have you had any major operations? | Y | N |
| 4. If yes to question number 3, what operations? _____ | | |
| 5. Have you had unusual reactions to any drugs? | Y | N |
| 6. If yes, please list _____ | | |
| 7. Any reaction to local anesthetic? | Y | N |
| 8. Have you ever had any of the following? | Y | N |
| 9. ___ Heart Ailment | ___ Any Blood Disease? | |
| 10. ___ High Blood Pressure? | ___ Any Liver Disease? | |
| 11. ___ Low Blood Pressure? | ___ Any Kidney Disease? | |
| 12. ___ Respiratory Disease? | ___ Any Stomach or Intestinal Disease? | |
| 13. ___ Diabetes? | ___ Any Venereal Disease? | |
| 14. ___ Rheumatic Fever? | ___ Yellow Jaundice or Hepatitis? | |
| 15. ___ Rheumatism or Arthritis? | ___ Epilepsy? | |
| 16. ___ Tumors or Growths? | ___ Aids? | |
| 17. Are you now taking drugs or medications? | Y | N |
| 18. If yes, please list _____ | | |
| 19. Are you pregnant? | Y | N |
| 20. Do you have a history of fainting? | Y | N |
| 21. Have you received any donor organs? | Y | N |
| 22. ___ Artificial Heart Valves? | ___ Vessels? | |
| 23. ___ Joint Implants? | ___ Or use a pacemaker? | |

DENTAL HISTORY

- | | | |
|---|---|---|
| 24. Do you have any specific problems? If so, please list _____ | Y | N |
| 25. Do you have pain in or near your ears? | Y | N |
| 26. Have you noticed any growth or sore spots in your mouth? | Y | N |
| 27. Does clenching your teeth hurt? | Y | N |
| 28. Have you ever had prolonged bleeding? | Y | N |
| 29. Do your gums bleed? | Y | N |
| 30. Do you know proper gum care? | Y | N |
| 31. Do you clench your teeth? | Y | N |
| 32. When was your last full mouth x-ray taken? | Y | N |
| 33. If you have a prosthesis (crown, denture, partial, etc...), when was it placed? _____ | | |
| 34. I certify the answers above are correct | Y | N |
| 35. Pharmacy Name/Phone Number _____ | | |
| 36. In case of emergency, notify _____ | | |
| 37. Phone _____ | | |

Payment is requested at the time of service. If my account becomes past due (60 Days After the Date of Service), I agree to pay a finance charge of 18% ANNUAL PERCENTAGE RATE (1.5% per month) on my unpaid account balance.

Signature _____

Date _____