**Walter Stoll, D.D.S.** **Medical History Questionnaire**

**NAME**_____ **Birthdate**_____

**Date of last dental exam** _____ **Date of last physical exam** _____

| | | |
|---|---|---|
| **Have you ever had excessive bleeding or other complications following an injury or a surgical procedure?** | **Yes** | **No** |
| **Have you ever broken out with a rash or had any other allergic reaction after taking medication or having an injection? If so, what medication?** | **Yes** | **No** |
| **Have you ever had high blood pressure?** | **Yes** | **No** |
| **Have you ever had heart problems, including valvular disorders or murmurs?** | **Yes** | **No** |
| **Have you had any joint replacements? If so, what?** | **Yes** | **No** |
| **Do you have AIDS or have you tested positive for the AIDS (HIV) virus?** | **Yes** | **No** |
| **Do you have diabetes?** | **Yes** | **No** |
| **Have you ever had rheumatic fever?** | **Yes** | **No** |
| **Have you ever had any type of hepatitis? If so, what type?** | **Yes** | **No** |
| **Have you been under the care of a physician recently?** | **Yes** | **No** |
| **Are you pregnant? If so, how many months?** | **Yes** | **No** |
| **Have you ever received radiation therapy?** | **Yes** | **No** |
| **Are you taking any medications at this time? If so, what?** | **Yes** | **No** |
| **Are you satisfied with the color of your teeth?** | **Yes** | **No** |
| **Are you satisfied with the shape, size, and position of your teeth?** | **Yes** | **No** |
| **Do you like your smile?** | **Yes** | **No** |

**Signature**_____ **Date** _____

**Comments** _____

_____

**Review dates** _____

**Walter Stoll, D.D.S.** **Cosmetic & Family Dentistry**

## Patient Registration & Financial Policy

**Patient Name** _____

**Date of Birth** _____ **S.S. #** _____

**Home Address** _____

**City/State** _____ **Zip** _____

**Home Phone** _____ **Cell Phone** _____

**Place of Employment** _____

**Work Address** _____

**Work Phone** _____

**Person Responsible for Account** _____

**Date of Birth** _____ **S.S. #** _____

**Home Address** _____

**City/State** _____ **Zip** _____

**Home Phone** _____ **Cell Phone** _____

**Place of Employment** _____

**Work Address** _____

**Work Phone** _____

**Do You Have Dental Insurance?** _____ **If so, please give us your card to copy.**

**Signature** _____ **Date** _____

**Review dates** _____

# FINANCIAL POLICY

**Generally, payment of all fees is due at the time of treatment. However, if your treatment is being submitted to an insurance carrier and you prefer that their payment come directly to us, we ask that you make payment of your estimated portion of the fee plus your deductible, at the time of treatment. When you are notified of your carrier's payment, you are responsible for any remaining balance. This payment is due immediately.**

**Fees for all emergency treatment and cosmetic procedures must be paid in full when treatment is rendered. If an insurance carrier is involved, your claim will be promptly submitted by our office. Your insurance carrier will then send their payment to you directly. A 25% deposit of the estimated fee is required to reserve an appointment for any cosmetic procedure.**

**Our office accepts VISA, Master Card, and Discover for payment of dental fees. We also offer alternative financing to qualified patients. We appreciate the fact that most of our patients promptly pay their balance. In the event that your account goes beyond 60 days past the treatment date, a monthly charge of 1 1/2% (.015) of the unpaid balance will be added to your account. All payments should be received in our office by the closing date of the 25th of each month.**

**The above policy includes insurance claims. We feel that 60 days should be a sufficient length of time for your carrier to issue payment. Please be assured that your claims will be submitted promptly after we received properly completed and signed forms.**

## Our Practice Philosophy and What About Insurance?

**We take pride in offering the highest quality of dental treatment and continuously incorporate the latest techniques and materials into our procedures. The resulting "state of the art" treatment may not always be included in the codes your insurance carrier lists, although they are all accepted by The American Dental Association. Insurance carriers will usually substitute procedure codes that most clearly match the advanced codes. This is especially true with the new, technically difficult, cosmetic procedures. Often, carriers do not update their payment schedules in a timely manner. These factors can result in underpayment to the patient. Many insurance carriers have also recently reduced or eliminated benefit payments on many, previously covered, procedures in an effort to reduce premiums.**

**We sincerely regret these recent trends, but want to reassure every patient that our loyalty remains with them and with treatment excellence. We will continue to offer only the finest, most advanced dental procedures and materials.**

**I have read and understand the above policy.**

_____ **Date** _____

# Stoll Smile Studio

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, have received a copy of this office's Notice of Privacy Practices.

_____

(Please Print Full Name)

_____

(Signature) (Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

◯ Individual refused to sign

◯ Communications barriers prohibited obtaining the acknowledgement

◯ An emergency situation prevented us from obtaining acknowledgement

◯ Other (Please Specify)

_____

_____

_____

Walter Stoll, DDS, 4206 North Holland Sylvania Rd., Toledo, OH 43623 419-882-2085

# Stoll Smile Studio

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_____

_____

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