

Anthony R. Cheslock D.D.S.
Patient Acquaintance Form

Name _____ Address _____
City _____ State _____ Zip _____ Home Phone _____
Work Phone _____ Sex (M/F) _____ Marital Status _____
Birthdate _____ Social Sec. # _____ Driv. Lic # _____
Email Address _____
Name of Responsible Party _____
Billing Address _____
Insurance (Y/N) _____ Employer Name _____ Phone _____
Address _____ City _____ State _____ Zip _____
Insurance Company Name _____ Phone _____
Referred By _____
CELL PHONE _____

1. I HEREBY ASSIGN INS. BENEFITS TO THE ATTENDING DENTIST
___Yes___No
2. Are you in good Health? ___Yes___No
3. Are you under the regular care of a physician?. ___Yes___No
4. Are you taking any medications regularly?. ___Yes___No
5. List _____
- DO YOU OR HAVE YOU EVER HAD:
6. Heart trouble (Palpitations, Angina, Rythm Problems Etc).
___Yes___No
7. Heart Murmur or heart valve problems. ___Yes___No
8. Heart or blood vessel surgery. ___Yes___No
9. Any type of joint surgery, replacement, or pins. ___Yes___No
10. High or low blood pressure (circle). ___Yes___No
11. Diabetes. ___Yes___No
12. Rheumatic Fever. ___Yes___No
13. Tuberculosis. ___Yes___No
14. Asthma. ___Yes___No
15. Hepatitis. ___Yes___No
16. Bleeding Problems. ___Yes___No
17. Do you have drug allergies (List) _____
18. Ever had a reaction to local anesthetic such as novocaine?
___Yes___No
19. Are you or is there a possibility you could be pregnant
___Yes___No
20. Have you been tested for the HIV virus? ___Yes___No
Date _____ Results _____
21. Is there any surgery or health treatment no mentioned?
___Yes___No
22. List _____
23. Physicians name and phone # _____
24. Pharmacy name and phone # _____
25. In case of Emergency Notify Phone _____
Patient Signature _____ Date _____
Relationship to patient (Minors) _____