Dental Designs of Stroud

General Dentistry for the Entire Family

THESE QUESTIONS ARE OF GREAT VALUE IN AIDING US TO A BETTER UNDERSTANDING OF YOUR HEALTH

Patient's Full Name: (Please Print) Nickname	M F	Age	Date of Birth
Reason for visit:	Social Security #:		
Referred by: (We'd like to thank them)			

MEDICAL HISTORY

Patient's Physician:	City:	Date last seen by physician:

		YES	NO
1.	Are you presently under the care of a physician for any medical problem(s)?		
	If yes, please provide explanation:		
2.	Are you currently taking any medications?		
	List all medications:		
3.	Have you ever been hospitalized or had surgery?		
	If yes, provide explanation:		
4.	Are you allergic to any medication, food or metals?		
	If yes, list all allergies:		
5.	Do you have, or have you ever had high blood pressure?		
6.	Do you smoke? ☐ YES ☐ NO If yes, how much daily? Do you use tobacco?		

Check the boxes below if you **HAVE** a history of any of the following:

☐ Heart trouble or murmurs	☐ Brain Injury	☐ Kidney/liver involvement	
☐ Rheumatic Fever	☐ Diabetic	☐ Hepatitis A	
☐ Allergies	☐ Asthma	☐ Hepatitis B	
☐ Drug Sensitivities	☐ Epilepsy	☐ Bleeding problems	
☐ AIDS	☐ Seizures	☐ Blood Disorder	☐ NONE

DENTAL HISTORY

First Dental Visit? ☐ YES ☐ NO	Name of Previous Dentist:	City:	Date of last dental visit? Month/Year

Any injuries to your teeth or jaws? (falls, blows, chips, etc.)		YES		NO	Explain:
Do you have a history of nail biting or thumb sucking		YES		NO	Explain:

Have you ever experienced any unfavorable reaction from previous medical or dental care?		YES		NO
If yes, please provide explanation:				
What is your main concern with your dental health?				
Do you wish to save all teeth possible?		YES		NO
Would you like to change the appearance or color of your teeth?		YES		NO
How often do you brush? Is dental floss used?		YES		NO

The following lines are for office use only – please complete the reverse side of this form

Date		Reviewed Health Hx	Changes		Initial	
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FAMILY INFORMATION				
Mailing Address:	City	State	Zip code	Home Phone:
Full Name of Patient:				Cell Phone:
Employed by:	Occupation:			Business Phone:
Full Name of Spouse:	Occupation			Cell Phone:
Spouse Employed by:				Business Phone:
E-Mail address:				
First name of all children and their ages:				
Has any member of your family been a patient in this office before?			YES	NO
If yes, please give name(s):				
Name of contact person (for emergencies)	Relationship:	Address:		Phone Number:

AUTHORIZATION AND FINANCIAL RESPONSIBILITY

Are you or your child covered by a dental plan? ☐ YES ☐ NO		Have you received previous care under this plan? ☐ YES ☐ NO	
Name of person insured:	Social Security Number:	Name of Insurance:	Group or Policy Number:
Are you or your children eligible for state/county aid? ☐ YES ☐ NO		Medicaid Number:	County:

I hereby authorize the doctor or the associates to perform any and all treatement and consent to such methods, drugs and agents as may be indicated in connection with dental care. I also authorize the doctor or any agent working in his behalf, to use any radiograph or photograph for scientific publication or presentation. This consent shall remain in effect until cancelled. I understand that payment is expected on the day of service. I agree to pay all legal fees, court costs, and interest charges to the doctor pertaining to the collection of my delinquent account.

Signature:	Date: