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

School (if patient is a minor)	Grade	Reason for visit:

Referred by: (We'd like to thank them)

MEDICAL HISTORY

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

		YES	NO
1.	Is patient presently under the care of a physician for any medical problem(s)?		
	If yes, please provide explanation:		
2.	Is patient currently taking any medications?		
	List all medications:		
3.	Has patient ever been hospitalized or had surgery?		
	If yes, provide explanation:		
4.	Is patient allergic to any medication, food or metals?		
	If yes, list all allergies:		
5.	Was patient premature?		

Check the boxes below if patient **HAS** 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 patient's teeth or jaws? (falls, blows, chips, etc.)		YES		NO	Explain:
Does patient have a history of nail biting/thumb sucking		YES		NO	Explain:

Has patient ever experienced any unfavorable reaction from previous medical or dental care?		YES		NO
If yes, please provide explanation:				
How do you think patient will act toward the dentist?				
How often does patient brush?	Is dental floss used?		YES	NO
Is brushing supervised?	Supervised by whom?			

Does patient receive: ☐ Fluoride vitamins ☐ Fluoride tablets/drops ☐ Fluoridated water ☐ None

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:
Father's full name:	Address:			Cell phone:
Father employed by:	Occupation:			Business Phone:
Mother's full name:	Address if different:			Cell Phone:
Mother employed by:	Occupation:			Business Phone:
E-Mail address:				
First name of all brothers and sisters 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) other than parent	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: