SHELLY STROMBOE DDS
Family & Cosmetic Dentistry

2902 West Beauregard
San Angelo, Texas 76901
325.949.0114

Welcome,
Dr. Shelly Stromboe & Staff are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. If you have any questions or need assistance, please ask us - we will be happy to help.

Date _____

Whom may we thank for referring you? _____

THE PATIENT

Name _____ SS# _____

☐ Single ☐ Married ☐ Child ☐ Other Birth date ___/___/___ Age _____ ☐ Male ☐ Female

Home Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Work (____) _____ ext. ___ Pager (____) _____

Cell (____) _____ E-mail Address _____

Employer _____ Occupation _____

Emergency Contact _____ Relationship _____ Phone _____

Please confirm my appointments at ☐ Home ☐ Work ☐ Cell ☐ E-mail address above

PERSON RESPONSIBLE FOR ACCOUNT

☐ Same as above

Name _____ Birth date ___/___/___ Relation _____

Billing Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Work (____) _____ Cell (____) _____

Employer _____ SS# _____

If a child has insurance from a parent not living with the child, the parent/guardian bringing the child to the appointment is responsible for all out of pocket fees regardless of insurance. We will be happy to assist with filing your insurance.

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name _____ Phone (____) _____ Group/Policy # _____

Insured's Name _____ Insured's Birth date ___/___/___ Relation _____

Insured's Social Security # _____ Insured's Employer _____

Secondary Insurance

Insurance Co. Name _____ Phone (____) _____ Group/Policy # _____

Insured's Name _____ Insured's Birth date ___/___/___ Relation _____

Insured's Social Security # _____ Insured's Employer _____

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DENTAL HISTORY

1. What is the reason for your visit today? _____
2. Date of last dental visit _____ Last dental cleaning _____ Last full mouth X-Rays _____
3. Previous Dentist _____
4. How often do you brush your teeth? _____ How often do you floss? _____
5. Do you have active decay or gum disease? ☐ Yes ☐ No
6. Do your gums ever bleed? ☐ Yes ☐ No
7. Does food catch between your teeth? ☐ Yes ☐ No
8. Do you ever have clicking, popping or discomfort in the jaw joint? ☐ Yes ☐ No
9. Do you grind your teeth? ☐ Yes ☐ No
10. Do you smoke or chew? ☐ Yes ☐ No
11. Do you have any dental problems now? ☐ Yes ☐ No
12. Have your past experiences in a dental office been positive? ☐ Yes ☐ No
13. Do you feel nervous about dental treatment? ☐ Yes ☐ No
14. Have you ever been told to take a pre-medication prior to dental treatment? ☐ Yes ☐ No

SMILE EVALUATION

1. Do you like the overall appearance of your teeth, your smile? ☐ Yes ☐ No
   If no, please describe _____
2. Are you happy with the color of your teeth? ☐ Yes ☐ No
   If no, please describe _____
3. Would you like for your teeth to be whiter? ☐ Yes ☐ No
4. Would you like for your teeth to be straighter? ☐ Yes ☐ No
   Explain _____
5. Do you have spaces between your teeth that you would like closed? ☐ Yes ☐ No
   If so, where? _____
6. Do you like the shape of your teeth? ☐ Yes ☐ No
   If no, please describe _____
7. Do you have missing teeth that you would like to replace? ☐ Yes ☐ No
8. Do you have old silver filings that you would like to replace with tooth-colored fillings? ☐ Yes ☐ No
   Explain _____

MEDICAL / DENTAL UPDATES

DATE	EXCEPTIONS		REVIEWED BY	BP
		None ☐		
		None ☐		
		None ☐		
		None ☐		
		None ☐		
		None ☐		

PATIENT NAME: _____

Medical History

Patient Name _____

Primary Care Physician _____

Do you have or have you ever had any of the following? Please check those that apply

Height: _____ Weight: _____

- ☐ Heart (Surgery, Disease, Attack)
- ☐ Chest Pain
- ☐ Congenital Heart Disease
- ☐ Heart Murmur
- ☐ High/Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Artificial Heart Valve/Pacemaker
- ☐ Artificial Joints (Hip, Knee, etc.)
- ☐ Bleeding Problems/Bruise Easily
- ☐ Rheumatic Fever
- ☐ Arthritis/Rheumatism
- ☐ Long term steriod use
- ☐ Swollen Ankles
- ☐ Stroke
- ☐ Diet (Special/Restricted)
- ☐ Ulcers
- ☐ Kidney problems
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Glaucoma
- ☐ Emphysema
- ☐ Chronic Cough
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Allergies/Hives
- ☐ Sinus problems
- ☐ Radiation Therapy
- ☐ Chemotherapy
- ☐ Tumors
- ☐ Hepatiatis A B C (circle)
- ☐ Sexually Trasmitted Infections
- ☐ AIDS or HIV Positive
- ☐ Cold Sores / Fever Blisters
- ☐ Blood Transfusion
- ☐ Hemophilia
- ☐ Sickle Cell Disease
- ☐ Liver Disease / Jaundice
- ☐ Epilepsy / Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Nervous / Anxious
- ☐ Psychiatric / Psychological Care
- ☐ **None of the above**

YES NO

☐ ☐ Do you have any health problems that were not listed above?
If yes, explain _____

☐ ☐ Have you been admitted to a hospital or had a major surgery in the past five years?
If yes, explain _____

☐ ☐ Are you taking any medications, pills, drugs, herbals, or supplements?
If yes, list _____

☐ ☐ Are you allergic to any medications or substances?
If yes, please circle below
Aspirin Penicillin Codeine Acrylic Metal Latex Other_____

☐ ☐ History of smoking, smokeless tobacco, vaping, or e-cigarettes?

☐ ☐ Have you ever taken bone loss prevention: Fosamax, Actonel, Boniva or other similar drugs?
If yes, list _____ Duration _____

WOMEN (Please Circle) Pregnant Trying to get pregnant Nursing Taking oral contraceptives

To the best of my knowledge, all of the preceding answers are correct. If I have changes in my health status or if my medications change, I will inform the doctor at my next appointment.

x _____ Date _____

Signature or patient, parent or guardian

Reviewed by _____ Date _____ BP_____ Pulse_____

Findings _____BMI_____

_____

_____

_____

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APPOINTMENTS

We value your time so you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time since we have reserved our time just for you. Please make every effort not to change your scheduled appointment. If you must change an appointment, please provide us at least **24 hours notice** so that we may accommodate other patients. Broken and missed appointments are subject to a $30 cancellation fee.

FINANCIAL POLICY

Unless another financial option is PRE-ARRANGED, payment in full is due the day of treatment. Should a patient have dental insurance with assignment to Dr. Stromboe, the estimated patient portion will be the amount due. Insurance payments without assignment will be sent to the insured with payment due in full. All emergency services / visits require payment in full regardless of insurance.

Payment Options

1. For your convenience we accept Cash, Check, Visa, MasterCard, Amex & Discover.
2. We also offer short and long-term financing options. (Interest-free options may apply, with approved credit)

For Patients with Dental Insurance

Dental insurance plans often pay less than the actual fee for service, therefore the patient or guarantor is the responsible party for all dental services provided. Dental insurance in most cases is a benefit with limitations and should not be expected to take care of all costs.

Fees

Returned checks are subject to a $30 accounting fee.

AUTHORIZATION AND CONSENT

General Consent to Treatment

I agree and consent to a dental examination by Dr. Stromboe. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize Dr. Stromboe to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Dr. Stromboe.

Photography Release

I authorize Dr. Stromboe to take intraoral photographs to help me better understand my current dental condition and possible treatment options. I also authorize her to use these anonymous photographs to educate other patients.

I understand and will comply with office **Appointment Policy**.
I understand that a copy of the **Notice of Privacy Practices** is available upon request.
I understand and will comply with the office **Financial Policy**.
I understand and agree to the **General Consent to Treatment**.
I authorize the **Release of Information**.
I authorize anonymous intraoral **Photographs** to be taken and used to educate me and other patients.

X _____ Date _____
Signature of patient, parent or guardian