

# Starr General Dentistry

6400 Cobbs Drive Suite 500 Waco, Texas 76710

(254)776-7410

(254)776-6207(fax)

## Medical History and Health Information

Patient Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Date of Last Dental Visit: \_\_\_\_\_ Date of last cleaning: \_\_\_\_\_ Date of last x-rays: \_\_\_\_\_

Reason for this visit: \_\_\_\_\_

Preferred Doctor: **Kent Starr** **Taylor Starr** **Martin Starr**

Name of the person or office referring you to our practice: \_\_\_\_\_

List of Current Medications: \_\_\_\_\_  
\_\_\_\_\_

### Medication Allergies and Adverse Reactions:

- Latex or Rubber Products
- Local Anesthetic
- Sulfa Drugs
- Penicillin or other antibiotics

(indicate which) \_\_\_\_\_

- Aspirin
- Codeine or other narcotics
- Barbiturates or sleeping pills

Other: \_\_\_\_\_

### Have you ever had any of the following? Please check those that apply:

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> AIDS/Immune Disorder                           | <input type="checkbox"/> Dizziness                 | <input type="checkbox"/> Jaundice                                   | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Allergies/ Hay Fever                           | <input type="checkbox"/> Epilepsy                  | <input type="checkbox"/> Kidney Disease                             | <input type="checkbox"/> Sinus Problems       |
| <input type="checkbox"/> Anemia   | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Liver Disease                              | <input type="checkbox"/> Stomach Ulcers       |
| <input type="checkbox"/> Arthritis                                      | <input type="checkbox"/> Fainting                  | <input type="checkbox"/> Low Blood Pressure                         | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Artificial Joints<br>Which _____<br>Date _____ | <input type="checkbox"/> Growths/ Tumors           | <input type="checkbox"/> Mental Disorders                           | <input type="checkbox"/> Thyroid Issues       |
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Head Injuries             | <input type="checkbox"/> Osteoporosis                               | <input type="checkbox"/> TMJ                  |
| <input type="checkbox"/> Blood Disease                                  | <input type="checkbox"/> Heart Disease             | <input type="checkbox"/> Pacemaker                                  | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Bleeding tendency                              | <input type="checkbox"/> Heart Murmur              | <input type="checkbox"/> Radiation Treatment to head, neck, or jaws | <b>Women:</b>                                 |
| <input type="checkbox"/> Cancer   | <input type="checkbox"/> Heart Stints              | <input type="checkbox"/> Respiratory Issues                         | <input type="checkbox"/> Taking Birth Control |
| <input type="checkbox"/> Diabetes                                       | <input type="checkbox"/> Hepatitis: type?<br>_____ |   | <input type="checkbox"/> Pregnancy or Nursing |
|   | <input type="checkbox"/> High Blood Pressure       |   | Due: _____                                    |

### Warning Signs of Periodontal (Gum) Disease

1. Do you have gums that bleed during tooth brushing?
  - Yes
  - No
2. Are your gums red, swollen, or tender?
  - Yes
  - No
3. Do you have gums that have pulled away from your teeth?
  - Yes
  - No
4. Do you have persistent bad breath?
  - Yes
  - No
5. Do you have pus between the teeth and gums?
  - Yes
  - No
6. Are your teeth loose or separating?
  - Yes
  - No
7. Have you noticed a change in the way your teeth fit together when you bite?
  - Yes
  - No
8. Have you noticed a change in the fit of your partial dentures?
  - Yes
  - No

Over 

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- Have you ever had any complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Are you wearing a removable dental appliance?  Yes  No
- Do you smoke or chew tobacco?  Yes  No If yes, how much/often?: \_\_\_\_\_
- Is there any history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you?  
 Yes  No If yes, please explain: \_\_\_\_\_
- Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Are you now under the care of a physician?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_
- Do you have any health problems that need further clarification? Other conditions you think the doctor should know about?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you wish to talk with the doctor privately about anything?  Yes  No

## Acknowledgement of Receipt of Notice of Privacy Practices

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

Signature: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Date: \_\_\_\_\_

Signature of patient, parent or guardian

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### BELOW TO BE COMPLETED BY THE DOCTOR

Comments on patient interview concerning medical history:

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Significant findings from questionnaire or oral interview:

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Dental management considerations:

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Date \_\_\_\_\_ Doctor's Signature \_\_\_\_\_