Starr General Dentistry

Patient Information

Patient Name: _____ (_____) Date: _____
Last First MI (Preferred Name)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Cell): _____ (Work): _____

Email: _____ Driver License #: _____

Address: _____
Street Apartment # City State Zip Code

Emergency Contact Name and Phone Number: _____

Responsible Party Information

Name: _____ Relation to Patient: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Cell): _____ (Work): _____

Address: _____
Street Apartment # City State Zip Code

Employer Name: _____ Current Patient of Starr Dentistry? ☐Yes ☐No

Address: _____
Street City State Zip Code

Preferred Method of Contact and Appointment Reminders

check all that apply: ☐ Cell ☐ Home ☐ Text ☐ Email

Dental Insurance Information

Primary

Subscriber: _____ Is the insured an existing patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID # or SSN: _____ Group #: _____

Insurance Carrier Name: _____

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary

Subscriber: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID # or SSN: _____ Group #: _____

Insurance Carrier Name: _____

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Consent for Services

The best dental health services are based on a friendly, mutual understanding between provider and patient. You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Statement of consent: I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided. I understand that dentistry is not an exact science and therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee has been made by anyone regarding the dental treatment I have requested and authorized.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

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: **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:

- ☐ AIDS
- ☐ Immune Disorder
- ☐ Allergies
- ☐ Hay Fever
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints Which_____ Date_____
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bleeding tendency
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Growths/ Tumors
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Stints Date: _____
- ☐ Hepatitis: type? _____
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Radiation Treatment to head, neck, or jaws
- ☐ Respiratory Issues
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Issues
- ☐ TMJ
- ☐ Tuberculosis

Women:

- ☐ Taking Birth Control
- ☐ Pregnancy or Nursing 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 ➡

Starr General Dentistry

- 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

BELOW TO BE COMPLETED BY THE DOCTOR

Comments on patient interview concerning medical history:

_____

_____

_____

Significant findings form questionnaire or oral interview:

_____

_____

_____

Dental management considerations:

_____

_____

Date_____ Doctor's Signature_____