Patient Information (CONFIDENTIAL)

How did you hear about us?_____

Star City Dental can now confirm appointments by Email or Text.
Please check your preference:
❑ Email ❑ Text ❑ Home Phone ❑ Cell Phone

Are you willing to be on a quick-fill list? ❑ Yes ❑ No
Patients receive a 10% discount off treatment or $20 credit for routine exam/cleaning when taking a quick fill appointment. You may receive numerous phone calls when there are cancellations.

Are you interested in our in-house payment program through care credit? ❑ Yes ❑ No

STAR CITY DENTAL

Name _____ Birthdate _____ Home Phone _____ ❑ M ❑ F

Address _____ City _____ State _____ Zip _____

Email _____ SS#_____ Cell Phone _____

If Full Time Student, Name of School/College _____ City _____ State _____

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Person to contact in case of emergency _____ Phone _____

Responsible Party (IF SAME AS PATIENT, SKIP TO THE NEXT SECTION)

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Birthdate _____Email _____ Cell Phone _____

Employer _____ Work Phone _____ SS#_____

Patient Dental History

Name of Previous Dentist and Location _____Date of Last Exam _____

1. Have you ever been diagnosed with periodontal disease?_____

_____

2. Do you like your smile? _____ How would you rate your smile on a scale from 1-10?_____

3. What changes would you make to improve your smile?_____

Insurance Information (IF CARD(S) IS AVAILABLE, SKIP TO THE NEXT SECTION)

PRIMARY INSURANCE

Name of Insured _____

Relationship to Patient _____

Birthdate _____

SS#/ID# _____

Name of Employer _____

Insurance Company _____

Group # _____

Policy ID # _____

SECONDARY INSURANCE

Name of Insured _____

Relationship to Patient _____

Birthdate _____

SS#/ID# _____

Name of Employer _____

Insurance Company _____

Group # _____

Policy ID # _____

Over Please...

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	❑	❑
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	❑	❑
If yes, please explain: _____		
3. Are you taking any medication(s) including non-prescription medicine?	❑	❑
If yes, what medication(s) are you taking? _____		
4. **PRE-MED** Do you require or has your physician recommended a pre-med antibiotic prior to dental treatment?	❑	❑
If yes, for what reason? _____		
5. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocaine)	❑	❑
Penicillin or any other Antibiotics (Please list)	❑	❑
_____		
Sulfa Drugs	❑	❑
Barbiturates	❑	❑
Sedatives	❑	❑
Iodine	❑	❑
Aspirin	❑	❑
Any Metals (e.g Nickel, Mercury, etc.)	❑	❑
Latex Rubber	❑	❑
Other (Please list)	❑	❑
_____		
_____		
_____		

	Yes	No
6. Do you use tobacco?	❑	❑
7. Do you use controlled substances?	❑	❑
8. **Are you taking any blood thinners?**	❑	❑
9. **Are you taking any bone strengthening medications (bisphosphonates)?**	❑	❑
10. Do you have Hepatitis or Jaundice?	❑	❑
11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	❑	❑
12. Do you have or have you had any of the following?		

	Yes	No
AIDS or HIV Infection	❑	❑
Anemia	❑	❑
Arthritis	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Cardiac Pacemaker	❑	❑
Diabetes	❑	❑
Emphysema	❑	❑
Epilepsy/Convulsions	❑	❑
Fainting/Seizures	❑	❑
Heart Attack	❑	❑
Date: _____		
Heart Disease	❑	❑
Heart Murmur	❑	❑
Heart Trouble	❑	❑
High Blood Pressure	❑	❑

	Yes	No
Joint Replacement or Implant	❑	❑
Date: _____		
Kidney Disease	❑	❑
Leukemia	❑	❑
Liver Disease	❑	❑
Low Blood Pressure	❑	❑
Mitral Valve Prolapse	❑	❑
Radiation Therapy	❑	❑
Respiratory Problems	❑	❑
Rheumatic Fever	❑	❑
Stroke	❑	❑
Date: _____		
Thyroid Problem	❑	❑
Tuberculosis	❑	❑
Other (please list)	❑	❑
_____		
_____		
_____		

	Yes	No
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	❑	❑
b) Are you nursing?	❑	❑
c) Are you taking oral contraceptives?	❑	❑

HIPAA Privacy Practices

I have read a copy of this office's Notice of Privacy Practices. By signing this form, I consent for your office to use and disclose my protected health information to carry out treatment, payment activities and healthcare operations. I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature of Patient *(or Parent/Guardian of Minor)* _____ Date _____

I give my permission to discuss my dental treatment (including but not limited to: Treatment, Scheduling, Billing, Insurance, etc.) with the following: _____

_____

Signature of Patient *(or Parent/Guardian of Minor)* _____ Date _____