John L. Starks DDS
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Patient Information (Confidential)

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

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

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

Email Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency Contact: _____ Relationship: _____

Phone#: _____

Referral Information

Whom may we thank for referring you to our practice? _____

_____

Responsible Party Information

Person responsible for payment:

Name: _____

Relationship to Patient: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Information

Primary Insurance Information:

Name of Insured: _____
Last First MI

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

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

Insurance Plan Name: _____

Secondary Insurance Information

Name of Insured: _____
Last First MI

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

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

Insurance Plan Name: _____

Health Information

Medical Health History

- 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? ☐ Yes ☐ No
  If yes, please explain: _____

Are you taking any medication(s) including non-prescription medicine? ☐ Yes ☐ No
If yes, please list:

_____

_____

Do you have or have you had any of the following? (Check all that apply)

☐Heart problems

☐Chest pain

☐Shortness of breath

☐Blood pressure problem

☐Heart murmur

☐Heart valve problem

☐Taking heart medication

☐Rheumatic fever

☐Pacemaker

☐Artificial heart valve

☐Blood problems

☐Easy bruising

☐Frequent nosebleed/Abnormal bleeding

☐Blood disease

☐Anemia

☐Ever require a blood transfusion?

☐Allergy problems

☐Hay fever

☐Sinus problems

☐Skin rashes

☐Taking allergy medication

☐Asthma

☐Intestinal problems

☐Ulcers

☐Weight gain or loss

☐Special diet

☐Constipation/diarrhea

☐Kidney or bladder problems

☐Fainting spells, seizures or epilepsy

☐Stroke(s)

☐Frequent or severe headaches

☐Thyroid problems

☐Persistent cough or swollen glands

☐Cancer/tumor

☐Diabetes

☐Urinate more than six times a day

☐Thirsty or mouth is dry much of the time

☐Family history of diabetes

☐Tuberculosis or other respiratory disease

☐Do you drink alcohol?
If so, how much? _____

☐Hepatitis, jaundice or liver trouble

☐Herpes or other STD

☐HIV positive/AIDS

☐Glaucoma

☐Do you wear contact lenses?_____

☐Head injury

☐Epilepsy or other neurologic disease

☐History of alcohol or drug abuse

During the past 12 months, have you taken any of the following?

☐Antibiotics or sulfa drugs

☐Anticoagulants (e.g., Coumadin)

☐High blood pressure medicine

☐Tranquilizers

☐Insulin, Orinase or similar drug

☐Aspirin

☐Digitalis or drugs for heart trouble

☐Nitroglycerin

☐Cortisone (steroids)

☐Natural remedies

☐Nonprescription drug/supplements

☐Other _____

Are you allergic, or have you reacted adversely, to any of the following?

☐**Local anesthetics (“Novocain”)**

☐**Penicillin or other antibiotics**

☐**Sulfa drugs**

☐**Barbiturates, sedatives or sleeping pills**

☐**Aspirin, acetaminophen or ibuprofen**

☐**Codeine, Demerol or other narcotics**

☐**Metals**

☐**Latex or rubber dam**

☐**Other**_____

Women

☐ Are you taking contraceptives or other hormones?_____

☐Are you pregnant?_____

☐If so, expected delivery date _____

☐Are you nursing?_____

☐Have you reached menopause?

If so, do you have any symptoms? _____

Dental Health History

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No

  If yes, please explain: _____

Are you apprehensive about dental treatment?	☐Yes ☐No
Have you had problems with previous dental treatment?	☐Yes ☐No
Do you gag easily?	☐Yes ☐No
Do you wear dentures?	☐Yes ☐No
Does food catch between your teeth?	☐Yes ☐No
Do you have difficulty chewing your food?	☐Yes ☐No
Do you chew on only one side of your mouth?	☐Yes ☐No
Do you avoid brushing any part of your mouth because of pain?	☐Yes ☐No
Do your gums bleed easily?	☐Yes ☐No
Do your gums bleed when you floss?	☐Yes ☐No
Do your gums feel swollen or tender?	☐Yes ☐No
Have you ever noticed slow-healing sores in or around your mouth?	☐Yes ☐No
Are your teeth sensitive?	☐Yes ☐No
Do you feel twinges of pain when your teeth come in contact with:	
Hot foods or liquids?	☐Yes ☐No
Cold foods or liquids?	☐Yes ☐No
Sour foods?	☐Yes ☐No
Sweets?	☐Yes ☐No
Do you take fluoride supplements?	☐Yes ☐No
Are you dissatisfied with the appearance of your teeth?	☐Yes ☐No
Do you prefer to save your teeth?	☐Yes ☐No
Do you want complete dental care?	☐Yes ☐No
How often do you brush? _____x a day	
How often do you floss? _____x a day	
Does your jaw make noise so that it bothers you?	☐Yes ☐No
or others?	☐Yes ☐No
Do you clench or grind your jaws frequently?	☐Yes ☐No
Do your jaws ever feel tired?	☐Yes ☐No
Does your jaw get stuck so that you can't open freely?	☐Yes ☐No
Does it hurt when you chew or open wide to take a bite?	☐Yes ☐No
Do you have earaches or pain in front of the ears?	☐Yes ☐No
Do you have jaw symptoms or headaches upon awaking in the morning?	☐Yes ☐No
Does jaw pain or discomfort affect your appetite, sleep, daily routine or other activities?	☐Yes ☐No
Do you find jaw pain or discomfort extremely frustrating or depressing?	☐Yes ☐No
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	☐Yes ☐No
Do you have a temporomandibular (jaw) disorder (TMD)?	☐Yes ☐No
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	☐Yes ☐No
Are you unable to open your mouth as far as you want?	☐Yes ☐No
Are you aware of an uncomfortable bite?	☐Yes ☐No
Have you had a blow to the jaw (trauma)?	☐Yes ☐No
Are you a habitual gum chewer or pipe smoker?	☐Yes ☐No

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

Consent for Treatment

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employs any such assistance as he/she deems appropriate.
I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others who may request my records.

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I acknowledge receipt of the **HIPAA Notice of Privacy Practices**.

I assign insurance benefits to the provider.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____
Signature of patient, parent or guardian

_____ Date: _____
Signature of guarantor of payment/responsible party