Robert L. Starr, D.D.S.

Patient's Personal and Health History Information

Patient Information

Last Name: _____ First Name: _____ Nickname: _____

Home Address:_____ City:_____ State:_____ Zip:_____

Soc. Sec. #:_____ Phone # (Home):_____(Work):_____

Cell #_____ Employer/Occupation_____

Employer's address: _____ Sex: M ☐ F ☐

Birth Date:_____ Do you have dental insurance? Yes ☐ No ☐ (If yes, please fill out section below.)

Referred by:_____ e-mail address_____

Primary Insurance

Person responsible for account: Last Name: _____ First Name:_____

Relationship to patient: Parent ☐ Guardian ☐ Self ☐ Other: _____ Sex: M ☐ F ☐

Home Address: (if different)_____ City:_____ State:_____ Zip:_____

Soc. Sec. #:_____ Phone # (Home):_____ (Work):_____

Cell #_____ Employer/Occupation_____

Employer's address: _____

Birth Date:_____ Insurance Company:_____

Contract #:_____ Group #:_____ Local #: _____

This insurance coverage is: Single ☐ Double ☐ Family ☐

Additional Insurance

Person responsible for account: Last Name:_____ First Name:_____

Relationship to patient: Parent ☐ Guardian ☐ Self ☐ Other:_____ Sex: M ☐ F ☐

Home Address (if different):_____ City:_____ State:_____ Zip: _____

Soc. Sec. #:_____ Phone # (Home): _____ (Work):_____

Cell #_____ Employer/Occupation_____

Employer's address: _____

Birth Date:_____ Insurance Company: _____

Contract #:_____ Group #:_____ Local #:_____

This insurance coverage is: Single ☐ Double ☐ Family ☐

Please complete both Sides

Health Information

Is your general health good? Yes ☐ No ☐

Physician's name: _____Phone #_____

Previous Dentist's name: _____Phone # _____

Date of last dental visit: _____

Have you experienced

Bleeding Problems.....Y ☐ N ☐	Chest pain .....Y ☐ N ☐	Fainting spells……Y ☐ N ☐
Jaundice .....Y ☐ N ☐	Seizures.....Y ☐ N ☐	Sinus problems……..Y ☐ N ☐
Snoring loudly .....Y ☐ N ☐	Fatigued during the day...Y ☐ N ☐	Stopped breathing....Y ☐ N ☐ during sleeping

Do you have or have you had

Heart disease.....Y ☐ N ☐	HIV / AIDS .....Y ☐ N ☐	Hepatitis.....Y ☐ N ☐
Heart attack ……Y ☐ N ☐	TMJ.....Y ☐ N ☐	Diabetes.....Y ☐ N ☐
Heart murmurs.....Y ☐ N ☐	Venereal disease.....Y ☐ N ☐	Glaucoma .....Y ☐ N ☐
High blood pressure.....Y ☐ N ☐	Liver disease .....Y ☐ N ☐	Arthritis.....Y ☐ N ☐
Prosthetic heart valve .....Y ☐ N ☐	Kidney/Bladder disease..Y ☐ N ☐	Rheumatism.....Y ☐ N ☐
Rheumatic fever.....Y ☐ N ☐	Sleep Apnea .....Y ☐ N ☐	Artificial joint.....Y ☐ N ☐
Stroke .....Y ☐ N ☐	T.B. .....Y ☐ N ☐	Ulcers.....Y ☐ N ☐
Pacemaker.....Y ☐ N ☐	Lung disease/asthma .....Y ☐ N ☐	Cancer/Tumors .....Y ☐ N ☐

Do you have an allergic reaction to

Penicillin.....Y ☐ N ☐	Codeine .....Y ☐ N ☐	Local anesthetic.....Y ☐ N ☐
Latex .....Y ☐ N ☐		
Other medications.....Y ☐ N ☐		

Please state the medications: _____

Medications

Are you currently taking any medication?.....Y ☐ N ☐

If yes, please state the medications: _____

Have you ever taken prescription Osteoporosis Medication (i.e.: Fosamax, Boniva)……..Y ☐ N ☐

For women only

Are you, or could you be pregnant or nursing? .....Y ☐ N ☐

Are you currently taking birth control pills?.....Y ☐ N ☐

For all patients

Do you have or have you had any other diseases or medical problems not listed above?.....Y ☐ N ☐

If yes, please state and explain: _____

Are you interested in cosmetic dentistry for yourself? .....Y ☐ N ☐

If yes please circle (i.e.: bleaching, bonding, porcelain veneers, implants, orthodontics…)

To the best of my knowledge, I have answered every question accurately. I will inform my dentist of any changes in my health and/or my medications. I have reviewed a copy of the **Dental Material Fact Sheet** (2004) and **Health Insurance Portability and Accountability Act's** (HIPAA) **Notice of Privacy Practices** (May 2016). I understand that I am responsible for payment for all dental services rendered. I understand that if I am covered by a third party payment service such as an insurance plan, your office may bill them directly as a convenience to me, but I am personally responsible for such charges until they are paid in full.

Signature of patient _____Date_____

Signature of guardian _____Date _____

Reviewed by: _____ Date:_____

Robert L. Starr, DDS